



MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT

HEARINGS BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE UNITED STATES SENATE NINETY-FIFTH CONGRESS

FIRST SESSION

ON

S. 1470

TO PROVIDE FOR THE REFORM OF THE ADMINISTRATIVE
AND REIMBURSEMENT PROCEDURES CURRENTLY EM-
PLOYED UNDER THE MEDICARE AND MEDICAID PRO-
GRAMS, AND FOR OTHER PURPOSES

JUNE 7, 8, 9, AND 10, 1977





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MEDICARE AND MEDICAID ADMINISTRATION AND REIMBURSEMENT REFORM ACT

TUESDAY, JUNE 7, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 8:35 a.m., in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Dole, and Danforth.

Senator TALMADGE. The subcommittee will come to order. Today, we begin 4 days of hearings on S. 1470, the Medicare and Medicaid Administrative and Reimbursement Reform Act. S. 1470, which I introduced joined by Senators Long, Ribicoff, Dole, and 16 other colleagues, is the successor proposal to S. 3205 of the last Congress. S. 3205 was the subject of 5 days of hearings last July.

[The committee press release announcing these hearings and the bill S. 1470 follows:]

[Press release, Committee on Finance, Subcommittee on Health]

FINANCE COMMITTEE ANNOUNCES HEARING ON MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM

Senator Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Senate Finance Committee, announced today that the Subcommittee will hold a hearing in early June on the various Medicare and Medicaid administrative and reimbursement reform provisions of S. 1470, introduced by Senator Talmadge on May 5, is cosponsored by a total of 19 Senators.

The hearing will be held beginning at 8:30 a.m. each day beginning June 7 through June 10 in Room 2221, Dirksen Senate Office Building.

Senator Talmadge stated: "S. 1470 is an improved version of S. 3205, a similar proposal introduced in the last Congress. The present bill incorporates constructive testimony received last year during five days of hearings on S. 3205. S. 1470 is designed to deal with, among other things, the problem of the continued explosion in the costs of the Medicare-Medicaid programs. Last year, I pointed out that those programs would cost Federal and State taxpayers more than \$38 billion in fiscal 1977. Bad as that was, just one year later these programs are estimated to cost Federal and State governments more than \$47 billion in fiscal 1978." Senator Talmadge said, with respect to soaring health costs: "The Congress and the Administration share a common concern; however, I believe we can best control costs by providing hospitals with equitable incentives and with the right kind of penalties."

Requests to testify.—Senator Talmadge advised that witnesses desiring to testify during this hearing make their request to testify to Michael Stern, Staff Director, Committee on Finance, 2227 Dirksen Senate Office Building, Washington, D.C. 20510, not later than Friday, May 27, 1977. Witnesses will be notified as soon as possible after this date as to when they are scheduled to appear.

Once the witness has been advised of the date of his appearance, it will not be possible for this date to be changed. If for some reason the witness is unable to appear on the date scheduled, he may file a written statement for the record of the hearing in lieu of a personal appearance.

Consolidated testimony.—Senator Talmadge also stated that the Subcommittee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Subcommittee. This procedure will enable the Subcommittee to receive a wider expression of views than it might otherwise obtain. Senator Talmadge urged very strongly that all witnesses exert a maximum effort to consolidate and coordinate their statements.

Legislative Reorganization Act.—In this respect he observed that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress "to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument."

Senator Talmadge stated that in light of this statute and in view of the large number of witnesses who have already formally requested an opportunity to appear before the Subcommittee in the limited time available for the hearing, all witnesses who are scheduled to testify must comply with the following rules:

(1) A copy of the statement must be filed by the close of business the day before the witness is scheduled to appear.

(2) All witnesses must include with their written statement a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 75 copies must be submitted before the beginning of the hearing.

(4) Witnesses are not to read their written statements to the Subcommittee, but are to confine their ten-minute oral presentations to a summary of the points included in the statement.

(5) Not more than ten minutes will be allowed for the oral summary. Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written statements.—Witnesses who are not scheduled for oral presentation, and others who desire to present their views to the Subcommittee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearings. These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building not later than June 20, 1977.

95TH CONGRESS
1ST SESSION

S. 1470

IN THE SENATE OF THE UNITED STATES

MAY 5 (legislative day, APRIL 28), 1977

Mr. TALMADGE (for himself, Mr. LONG, Mr. RIBICOFF, Mr. DOLE, Mr. NUNN, Mr. EASTLAND, Mr. MATSUNAGA, Mr. RANDOLPH, Mr. HOLLINGS, Mr. INOUE, Mr. GRAVEL, Mr. FORD, Mr. JAVITS, Mr. PELL, Mr. PERCY, Mr. BROOKE, Mr. BURDICK, Mr. STONE, Mr. METZENBAUM, and Mr. HATHAWAY) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs, and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*
- 3 That this Act may be cited as the "Medicare-Medicaid
- 4 Administrative and Reimbursement Reform Act".

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HOSPITAL REIMBURSEMENT REFORM

- Sec. 2. Criteria for determining reasonable cost of hospital services.
- Sec. 3. Payments to promote closing and conversion of underutilized facilities.
- Sec. 4. Federal participation in hospital capital expenditures.

1 “(8) For additional requirements applicable to deter-
2 mination of reasonable cost for services provided by hos-
3 pitals, see subsection (aa).”.

(b) Section 1864 of the Act is amended by adding after subsection (z) the following subsection:

6 "CRITERIA FOR DETERMINING REASONABLE COST OF
7 HOSPITAL SERVICES

8 “(aa) (1) To more fairly and effectively determine
9 reasonable costs incurred in providing hospital services, the
10 Secretary shall, not later than April 1, 1978, after consult-
11 ing with appropriate national organizations, establish—

“(A) an accounting and uniform functional cost reporting system (including uniform procedures for allocation of costs) for determining operating and capital costs of hospitals providing services, and

16 “(B) a system of hospital classification under
17 which hospitals furnishing services will initially be clas-
18 sified as follows:

19 “(i) by size, with each of the following groups
20 of hospitals being classified in separate categories:

(I) those having more than 5, but fewer than 25, beds, (II) those having more than 24, but fewer than 50, beds, (III) those having more than 49, but fewer than 100, beds, (IV) those having more than 99, but fewer than 200, beds, (V)

1 those having more than 199, but fewer than 300,
2 beds, (VI) those having more than 299, but fewer
3 than 400, beds, (VII) those having more than
4 399, but fewer than 500, beds, and (VIII) those
5 having more than 499 beds,

6 “(ii) by type of hospital, with (I) short-
7 term general hospitals being in a separate category,
8 (II) hospitals which are the primary affiliates of
9 accredited medical schools (with one hospital to
10 be nominated by each accredited medical school)
11 being in one separate category (without regard to
12 bed size), and (III) psychiatric, geriatric, mater-
13 nity, pediatric, or other specialty hospitals being in
14 the same or separate categories, as the Secretary
15 may determine appropriate, in light of any differ-
16 ences in specialty which significantly affect the rou-
17 tine costs of the different types of hospitals, and

18 “(iii) other criteria which the Secretary may
19 find appropriate, including modification of bed-size
20 categories;

21 but the system of hospital classification shall not differ-
22 entiate between hospitals on the basis of ownership.

23 “(2) The term ‘routine operating costs’ used in this
24 subsection does not include:

25 “(A) capital and related costs,

1 “(B) direct personnel and supply costs of hospital
2 education and training programs,

3 “(C) costs of interns, residents, and non-adminis-
4 trative physicians,

5 “(D) energy costs associated with heating and
6 cooling the hospital plant, and

7 “(E) malpractice insurance expense, or,

8 “(F) ancillary service costs.

9 “(3) (A) During the calendar quarter beginning on
10 January 1 of each year, beginning with 1979, the Secretary
11 shall determine, for the hospitals in each category of the
12 system established under paragraph (1) (B), an average
13 per diem routine operating cost amount which shall (except
14 as otherwise provided in this subsection) be used in deter-
15 mining payments to hospitals.

16 “(B) The determination shall be based upon the amount
17 of the hospitals' routine operating costs for the preceding
18 fiscal year.

19 “(C) In making a determination, the routine operating
20 costs of each hospital shall be divided into personnel and
21 nonpersonnel components.

22 “(D) (i) The personnel and nonpersonnel components
23 of routine operating costs for each of the hospitals (other
24 than for those excluded under clause (ii)) in each
25 category shall be added for all hospitals and then divided

1 by the total number of days of routine care provided by the
2 hospitals in the category to determine the average per diem
3 routine operating cost for each category.

4 “(ii) In making the calculations required by clause
5 (i), the Secretary shall exclude any hospital which has sig-
6 nificant understaffing problems or which otherwise experi-
7 ences significant cost differentials resulting from failure of
8 the hospital to fully meet the standards and conditions of
9 participation as a provider of services as determined by the
10 Secretary.

11 “(E) There shall be determined for each hospital in
12 each category a per diem payment rate for routine operating
13 costs. That payment rate shall equal the average per diem
14 routine operating cost amount for the category in which
15 the hospital is expected to be classified during the subsequent
16 fiscal year, except that the personnel component shall be
17 adjusted using a wage index based upon general wage levels
18 (including fringe benefit costs) in the areas in which the
19 hospitals are located. If the Secretary finds that, in an area
20 where one or more hospitals in any category are located,
21 for the fiscal year ending June 30, 1977, the wage level
22 (including fringe benefit costs) for hospitals is significantly
23 higher than the general wage level (including fringe bene-
24 fit costs) in that area (relative to the relationship between
25 hospital wages and general wages in other areas), then

1 the general wage level in the area shall be deemed equal
2 to the wage level for hospitals in that area, but only during
3 fiscal year 1979.

4 “(4) (A) (i) The term ‘adjusted per diem payment rate
5 for routine operating costs’, means the per diem payment rate
6 for routine operating costs plus the average percentage
7 increase in prices determined under succeeding provisions
8 of this subparagraph.

9 “(ii) In making payments for services, the Secretary
10 shall add a semiannual average percentage increase in the
11 cost of the mix of goods and services (including personnel
12 and nonpersonnel costs) comprising routine operating costs,
13 equal to the lesser of: (I) the average percentage increase
14 estimated by the hospital, or (II) the average percentage
15 increase in the area estimated by the Secretary.

16 “(iii) At the end of the fiscal year, the amounts paid
17 under clause (ii) shall be adjusted to reflect the lesser of
18 (I) the actual cost increase experienced by the hospital
19 or (II) the actual increase in costs which occurred in the
20 mix of goods and services in the area. Adjustments shall also
21 be made to take account of unexpected changes in the hos-
22 pital’s classification.

23 “(B) For purposes of payment the amount of routine
24 operating cost incurred by a hospital shall be deemed to
25 equal—

1 “(i) for a hospital which has actual routine oper-
2 ating costs equal to or greater than that hospital’s
3 adjusted per diem payment rate for routine operating
4 costs, an amount equal to the greater of:

5 “(I) The hospital’s actual routine operating
6 costs, but not exceeding 120 percent of the hos-
7 pital’s adjusted per diem payment rate for routine
8 operating costs, or

9 “(II) the amounts determined for the hospital
10 under clause (I) if it had been classified in the
11 bed-size category nearest to the category in which
12 the hospital was classified, but not exceeding the
13 hospital’s actual routine operating costs; and

14 “(ii) for a hospital which has actual routine operating
15 costs less than that hospital’s adjusted per diem pay-
16 ment rate for routine operating costs, an amount equal
17 to (I) the amount of the hospital’s actual routine op-
18 erating costs, plus (II) whichever is smaller: (a) 5
19 percent of the hospital’s adjusted per diem payment
20 rate for routine operating costs, or (b) 50 percent of
21 the amount by which the hospital’s adjusted per diem
22 payment rate for routine operating costs exceeds the
23 hospital’s actual routine operating costs.

24 “(C) Any hospital excluded by the Secretary under
25 paragraph (3) (D) (ii), shall be reimbursed for routine

1 operating costs the lesser of (i) actual costs or (ii) the
2 reimbursement determined under this subsection.

3 “(D) April 1 of the year in which the Secretary deter-
4 mines the amount of the average per diem operating cost for
5 each hospital category and the adjusted per diem payment
6 rate for each hospital, the determinations shall be published
7 by the Secretary; and the Secretary shall notify the hospital
8 administrator and the administrative governing body of each
9 hospital with respect to all aspects of the determination
10 which affect the hospital.

11 “(E) If a hospital is determined by the Secretary to
12 be—

13 “(i) located in an underserved area where hospital
14 services are not otherwise available,

15 “(ii) certified as being currently necessary by an
16 appropriate planning agency, and

17 “(iii) underutilized,
18 the adjusted per diem payment rate shall not apply to
19 that portion of the hospital's routine operating costs attrib-
20 utable to the underutilized capacity.

21 “(F) If a hospital satisfactorily demonstrates to the
22 Secretary that, in the aggregate, its patients require a sub-
23 stantially greater intensity of care than is generally provided
24 by the other hospitals in the same category, resulting in

1 unusually greater routine operating costs, then the adjusted
2 per diem payment rate shall not apply to that portion of
3 the hospital's routine operating costs attributable to the
4 greater intensity of care required.

5 “(G) The Secretary may further increase the adjusted
6 per diem payment rate to reflect the higher prices prevailing
7 in Alaska or Hawaii.

8 “(H) Where the Secretary finds that a hospital has
9 manipulated its patient mix, or patient flow, or provides less
10 than the normal range and extent of patient service, or where
11 an unusually large proportion of routine nursing service is
12 provided by private-duty nurses, the routine operating costs
13 of that hospital shall be deemed equal to whichever is less:
14 the amount determined without regard to this subsection,
15 or the amount determined under subparagraph (B).

16 “(5) Where any provisions of this subsection are in-
17 consistent with section 1861 (v), this subsection supersedes
18 section 1861 (v).”

19 (c) (1) The Secretary shall, at the earliest practical
20 date, develop additional methods for reimbursing hospitals
21 for all other costs, and for reimbursing all other entities
22 which are reimbursed on the basis of reasonable cost. Those
23 methods shall provide appropriate classification and reim-
24 bursement systems designed to ordinarily permit comparisons
25 of the cost centers of one entity, either individually or in

1 the aggregate, with cost centers similar in terms of size
2 and scale of operation, prevailing wage levels, nature, ex-
3 tent, and appropriate volume of the services furnished, and
4 other factors which have a substantial impact on hospital
5 costs. The Secretary shall provide procedures for appropriate
6 exceptions.

7 (2) The systems of reimbursement shall not permit
8 payment for costs which exceed 120 percent of the average
9 cost incurred by other institutions or agencies in the same
10 class, unless an exception has been allowed.

11 (3) The Secretary shall, as classification and reimburse-
12 ment systems methods are developed, but not later than two
13 years from enactment, submit appropriate legislative recom-
14 mendations to the Congress.

15 (d) The provisions of section 1861(aa) (2), (3),
16 and (4) of the Social Security Act—

17 (1) shall apply for informational purposes for
18 services furnished by a hospital before October 1, 1979,
19 and

20 (2) shall be effective for fiscal years beginning
21 with fiscal year 1981.

22 (e) Notwithstanding any other provision of this Act,
23 where the Secretary has entered into a contract with a State,
24 as authorized under section 222 of Public Law 92-603 or
25 section 1533 (d) of the Public Health Service Act, to estab-

lish a reimbursement system for hospitals, hospital reimbursement in that State under titles XVIII and XIX shall be based on that State system, if the Secretary finds that—

(1) the State has mandated the reimbursement system and it applies to all hospitals in the State which have provider agreements under title XVIII or title XIX;

(2) the system applies to all revenue sources for hospital services in the State;

(3) all hospitals in the State with which there is a provider agreement conform to the accounting and uniform reporting requirements of section 1861(aa) (1) (A), and furnishes any appropriate reports that the Secretary may require; and,

(4) (A) based upon an annual evaluation of the system, aggregate payments to hospitals in the State under title XVIII and title XIX for those components of hospitals costs determined under section 1861(aa) for the fiscal year following an annual evaluation are estimated to be less than payments would be under section 1861(aa) or, (B) where a State that is unable to satisfy requirements of subparagraph (A) demonstrates to the satisfaction of the Secretary that total reimbursable inpatient hospital costs in the

1 State are lower than would otherwise be payable under
2 title XVIII and title XIX.

3 If the Secretary finds that any of the above conditions
4 in a State which previously met them have not been met
5 for a year the Secretary shall, after due notice, reimburse
6 hospitals in that State according to the provisions of this
7 Act unless he finds that unusual, justifiable and non-
8 recurring circumstances led to the failure to comply.

9 (f) (1) Section 1866 (a) (1) of the Social Security
10 Act is amended by inserting “, and” in place of the period
11 at the end of subparagraph (C), and by adding a subpara-
12 graph: “(D) not to increase amounts due from any indi-
13 vidual, organization, or agency in order to offset reductions
14 made under section 1861 (aa) in the amount paid, or ex-
15 pected to be paid, under title XVIII.”.

16 (2) Section 1902 (a) (27) of the Social Security Act is
17 amended by deleting “and” at the end of subparagraph
18 (A), by inserting “, and” in place of the semicolon at the
19 end of subparagraph (B) and by adding a new subpara-
20 graph:

21 “(C) not to increase amounts due from any individual
22 organization, or agency in order to offset reductions made
23 under section 1902 (a) (13) (D) in the amount paid, or ex-
24 pected to be paid under title XIX;”

1 (h) Section 1902 (a) (13) (D) is amended to read as
2 follows:

3 “(D) for payment of the reasonable cost of inpa-
4 tient hospital services provided under the plan, applying
5 the methods specified in section 1861 (v) and section
6 1861 (aa), which are consistent with section 1122;
7 and”.

8 PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF
9 UNDERUTILIZED FACILITIES

10 SEC. 3. (a) Part A of title XI of the Social Security
11 Act is amended by adding at the end the following new
12 section:

13 “PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF
14 UNDERUTILIZED FACILITIES

15 “SEC. 1132. (a) (1) (A) Before the end of the third
16 full month following the month in which this section is en-
17 acted, the Secretary shall establish a Hospital Transitional
18 Allowance Board (referred to in this section as the ‘Board’).
19 The Board shall have five members, appointed by the Sec-
20 retary without regard to the provisions of title 5, United
21 States Code, governing appointments in the competitive
22 service, who are knowledgeable about hospital planning and
23 hospital operations.

24 “(B) Members of the Board shall be appointed for
25 three-year terms, except some initial members shall be ap-

1 pointed for shorter terms to permit staggered terms of office.

2 “(C) Members shall be entitled to per diem compen-
3 sation at rates fixed by the Secretary, but not more than
4 the current per diem equivalent at the time the service in-
5 volved is rendered for grade GS-18 in section 5332 of title
6 5, United States Code.

7 “(D) The Secretary shall provide technical, secretarial,
8 clerical, and other assistance as the Board may need.

9 “(2) The Board shall receive, and act upon applications
10 by hospitals certified for participation (other than as ‘emer-
11 gency hospitals’) under titles XVIII and XIX for transi-
12 tional allowances.

13 “(b) For purposes of this section—

14 “(1) The term ‘transitional allowance’ means an amount
15 which—

16 “(A) shall, solely by reason of this section, be in-
17 cluded in a hospital’s reasonable cost for purposes of cal-
18 culating payments under the programs authorized by
19 titles V, XVIII, and XIX, of this Act; and

20 “(B) in accordance with this section, it is estab-
21 lished by the Secretary for a hospital in recognition of
22 a reimbursement detriment (as defined in paragraph
23 (3)) experienced because of a qualified facility con-
24 version (as defined in paragraph (2)).

25 “(2) The term ‘qualified facility conversion’ means

1 closing, modifying, or changing usage of underutilized hos-
2 pital facilities which is expected to benefit the programs au-
3 thorized under title XVIII and title XIX by (i) eliminating
4 excess bed capacity, (ii) discontinuing an underutilized
5 service for which there are adequate alternative sources, or
6 (iii) substituting for the underutilized service some other
7 service which is needed in the area and which is consistent
8 with the findings of an appropriate health planning agency.

9 “(3) A hospital which has carried out a qualified con-
10 version and which continues in operation will be regarded
11 as having experienced a ‘reimbursement detriment’ (A)
12 to the extent that, solely because of the conversion there is
13 a reduction in the aggregate reimbursement (but only to
14 the extent the capital was accepted as reasonable for pur-
15 poses of reimbursement) which is considered in determining
16 for payment purposes under title XVIII or title XIX to the
17 hospital the reasonable cost (as the term is used for purposes
18 of those titles) incurred by the hospital; (B) if the conver-
19 sion results, on an interim basis, in increased operating costs
20 to the extent that operating costs exceed amounts ordinarily
21 reimbursable under titles XVIII and XIX, or (C) in the
22 case of complete closure of a nonprofit, nongovernmental
23 (except local governmental) hospital, other than for re-
24 placement of the hospital to the extent of actual debt
25 obligations previously recognized as reasonable for reim-

1 bursement, where the debt remains outstanding, less any
2 salvage value.

3 “(c) (1) Any hospital may file an application with the
4 Board (in a form and including data and information as
5 the Board, with the approval of the Secretary, may require)
6 for a transitional allowance with respect to any qualified
7 conversion which was formally initiated after December 31,
8 1977. The Board, with the approval of the Secretary, may
9 also establish procedures, consistent with this section, by
10 means of which a finding of a reimbursement detriment may
11 be made prior to the actual conversion.

12 “(2) The Board shall consider any application filed
13 by a hospital, and if the Board finds that—

14 “(A) the facility conversion is a qualified facility
15 conversion, and

16 “(B) the hospital is experiencing a reimbursement
17 detriment because it carried out the qualified facility
18 conversion,

19 the Board shall transmit to the Secretary its recommendation
20 that the Secretary establish, a transitional allowance for the
21 hospital in amounts reasonably related to prior or prospec-
22 tive use of the facility under titles XVIII and XIX, and for
23 a period, not to exceed twenty years, specified by the Board;
24 and, if the Board finds that the criteria in clauses (A) and
25 (B) are not met, it shall advise the Secretary not to estab-

1 lish a transitional allowance for that hospital. For an ap-
2 proved closure under subsection (b) (3) (C) the Board may
3 recommend or the Secretary may approve a lump-sum
4 payment in lieu of periodic allowances, where such payment
5 would constitute a more efficient and economic alternative.

6 “(3) (A) The Board shall notify a hospital of its find-
7 ings and recommendations.

8 “(B) A hospital dissatisfied with a recommendation
9 may obtain an informal or formal hearing at the discretion
10 of the Secretary, by filing (in the form and within a time
11 period established by the Secretary) a request for a hearing.

12 “(4) (A) Within thirty days after receiving a recom-
13 mendation from the Board respecting a transitional allow-
14 ance or, if later, within thirty days after a hearing the Sec-
15 retary shall make a final determination whether, and if so
16 in what amount and for what period of time, a transitional
17 allowance will be granted to a hospital. A final determination
18 of the Secretary shall not be subject to judicial review.

19 “(B) The Secretary shall notify a hospital and any other
20 appropriate parties of the determination.

21 “(C) Any transitional allowance shall take effect on a
22 date prescribed by the Secretary, but not earlier than the
23 date of completion of the qualified facility conversion. A tran-
24 sitional allowance shall be included as an allowable cost item

1 in determining the reasonable cost incurred by the hospital
2 in providing services for which payment is authorized under
3 this title": *Provided, however,* That the transitional allow-
4 ance shall not be considered in applying limits to costs
5 recognized as reasonable pursuant to the third sentence of
6 section 1861 (v) (1) and section 1861 (aa) of this Act
7 or in determining the amount to be paid to a provider
8 pursuant to section 1814 (b), section 1833 (a) (2), section
9 1910 (i) (3), and section 506 (f) (3) of this Act."

10 " (d) In determining the reasonable cost incurred by
11 a hospital with respect to which payment is authorized
12 under a State plan approved under title V or title XIX,
13 any transitional allowance shall be included as an allowable
14 cost item.

15 " (e) (1) The Secretary shall not, prior to January 1,
16 1981, establish a transitional allowance for more than a total
17 of fifty hospitals.

18 " (2) On or before January 1, 1980, the Secretary shall
19 report to the Congress evaluating the effectiveness of the
20 program established under this section including appropriate
21 recommendations."

22 (b) The amendments made by subsection (a) shall
23 apply only to services furnished by a hospital or skilled
24 nursing facility for fiscal years beginning on and after the

1 first day of the first calendar month following enactment
2 of this Act.

3 FEDERAL PARTICIPATION IN HOSPITAL CAPITAL

4 EXPENDITURES

5 SEC. 4. (a) Section 1122 (b) of the Social Security
6 Act is amended to read:

7 “(b) For purposes of this section, the State Health
8 Planning and Development Agency designated under sec-
9 tion 1521 of the Public Health Service Act shall serve as
10 the designated planning agency.”

11 (b) Section 1122 (c) is amended to read:

12 “(c) Expenses incurred by planning agencies shall be
13 payable from—

14 “(i) funds in the Federal Hospital Insurance Trust
15 Fund,

16 “(ii) funds in the Federal Supplementary Medical
17 Insurance Trust Fund, and

18 “(iii) funds appropriated to carry out the health
19 care provisions of the several titles of this Act,

20 in amounts as the Secretary finds results in a proper alloca-
21 tion. The Secretary shall transfer money between the funds
22 as may be appropriate to settle accounts between them. The
23 Secretary shall pay the planning agencies without requiring
24 contribution of funds by any State or political subdivision.”

25 (c) Section 1122 (d) is amended to read:

1 “(d) (1) Except as provided in paragraph (2), if the
2 Secretary determines that—

3 “(A) neither the Health Systems Agency nor the
4 designated planning agency had been notified of any
5 proposed capital expenditure at least sixty days prior to
6 obligation for the expenditure; or

7 “(B) (i) the designated planning agency had not
8 approved the proposed expenditure; and

9 “(i) the designated planning agency had granted
10 to the person proposing the capital expenditure an op-
11 portunity for a fair hearing with respect to the findings;
12 then, in determining Federal payments under titles V,
13 XVIII, and XIX for services furnished in the health care
14 facility for which the capital expenditure is made, the Secre-
15 tary shall not include any amount attributable to deprecia-
16 tion, interest on borrowed funds, a return on equity capital
17 (in the case of proprietary facilities), other expenses related
18 to the capital expenditure, or for direct operating costs, to
19 the extent that they can be directly associated with the
20 capital expenditure. In the case of a proposed capital ex-
21 penditure in a standard metropolitan statistical area which
22 encompasses more than one jurisdiction, that expenditure
23 shall require approval of the designated planning agency of
24 each jurisdiction who shall jointly review the proposal.

1 Where the designated planning agencies do not unanimously
2 agree, the proposed expenditure shall be deemed disapproved;
3 where the designated planning agencies do not act to approve
4 or disapprove the proposed expenditure within one hundred
5 and eighty days of submission of request for approval the
6 proposed expenditure shall be deemed approved; any deemed
7 approval or disapproval shall be subject to review and
8 reversal by the Secretary following a request submitted to
9 him within sixty days of the deemed approval or disapproval,
10 for a review and reconsideration based upon the record. With
11 respect to any organization which is reimbursed on a per
12 capita, fixed fee, or negotiated rate basis, in determining the
13 Federal payments to be made under titles V, XVIII, and
14 XIX, the Secretary shall exclude an amount reasonably
15 equivalent to the amount which would otherwise be excluded
16 under this subsection if payment were made on other than a
17 per capita, fixed fee, or negotiated rate basis.

18 “(2) If the Secretary, after submitting the matters in-
19 volved to the advisory council, determines that an exclusion
20 of expenses related to any capital expenditure would dis-
21 courage the operation or expansion of any health care facility
22 or health maintenance organization which has demonstrated
23 to his satisfaction proof of its capability to provide compre-
24 hensive health care services (including institutional services)
25 effectively and economically, or would be inconsistent with

1 effective organization and delivery of health services or ef-
 2 fective administration of title V, XVIII, or XIX, he shall
 3 not exclude the expenses pursuant to paragraph (1).”

4 (d) Section 1122 (g) of the Social Security Act is
 5 amended to read:

6 “(g) For purposes of this section, a ‘capital expenditure’
 7 is one which, under generally accepted accounting principles,
 8 is not properly chargeable as an expense of operation and
 9 maintenance and which (1) exceeds \$100,000, (2) changes
 10 the bed capacity of the facility, or (3) substantially changes
 11 the services of the facility, including conversion of existing
 12 beds to higher cost usage. The cost of studies, surveys, de-
 13 signs, plans, working drawings, specifications, and other ac-
 14 tivities essential to the acquisition, improvement, expansion,
 15 or replacement of the plant and equipment shall be included
 16 in determining whether the expenditure exceed \$100,000.

17 (e) Section 1861 (z) of the Social Security Act is
 18 amended to read:

19 “Institutional Planning

20 “(z) An overall plan and budget of a hospital, skilled
 21 nursing facility, or home health agency shall—

22 “(1) provide for an annual operating budget which
 23 includes all anticipated income and expenses related to
 24 items which would, under generally accepted account-
 25 ing principles, be considered income and expense items

1 (except that nothing in this paragraph shall require
2 that there be prepared, in connection with any budget
3 an item-by-item identification of the components of each
4 type of anticipated expenditure or income) ;

5 “(2) provide for a capital expenditures plan for
6 at least a five-year period (including the year to which
7 the operating budget applies) which identifies in detail
8 the sources of financing and the objectives of each
9 anticipated expenditure in excess of \$100,000 related to
10 the acquisition of land, improvement of land, buildings,
11 and equipment, and the replacement, modernization, and
12 expansion of the buildings and equipment, and which
13 would, under generally accepted accounting principles,
14 be considered capital items. The capital expenditures
15 plan shall be a matter of public record and available in
16 readily accessible form and fashion;

17 “(3) provide for annual review and updating; and

18 “(4) be prepared, under the direction of the govern-
19 ing body of the institution or agency, by a committee
20 consisting of representatives of the governing body,
21 administrative staff, and medical staff (if any) of the
22 institution or agency.”

23 AGREEMENT BY PHYSICIANS TO ACCEPT ASSIGNMENTS

24 SEC. 10. (a) (1) Title XVIII of the Social Security
25 Act is amended by adding the following section:

1 "AGREEMENTS OF PHYSICIANS TO ACCEPT ASSIGNMENT

2 "SEC. 1868. (a) For purposes of this section the term
3 'participating physician' means a doctor of medicine or oste-
4 opathy who has in effect an agreement by which he agrees
5 to accept an assignment of claim (as provided for in section
6 1842 (b) (3) (B) (ii)) for each physicians' service (other
7 than those excluded from coverage by section 1862) per-
8 formed by him in the United States for an individual enrolled
9 under this part. The assignment shall be in a form prescribed
10 by the Secretary. The agreement may be terminated by
11 either party upon thirty days' notice to the other, filed in a
12 manner prescribed by the Secretary.

13 "(b) To expedite processing of claims from participat-
14 ing physicians, the Secretary shall establish procedures and
15 develop appropriate forms under which—

16 "(1) each physician will submit his claims on one
17 of alternative simplified approved bases, including mul-
18 tiple listing of patients, and the Secretary shall act to
19 assure that these claims are processed expeditiously, and

20 "(2) The physician shall obtain from each patient
21 enrolled under this part (except in cases where the Sec-
22 retary finds it impractical for the patient to furnish it),
23 and shall make available at the Secretary's request, a
24 signed statement by which the patient: (i) agrees to
25 make an assignment with respect to all services fur-

1 nished by the physician; and (ii) authorizes the release
2 of any medical information needed to review claims
3 submitted by the physician.

4 “(c) (1) Participating physicians shall be paid ad-
5 ministrative cost-savings allowances (as specified below in
6 this subsection) in addition to the reasonable charges that
7 are payable.

8 “(2) The administrative cost-savings allowance shall
9 equal \$1 and shall be paid to the participating physician for
10 each claim he submits in accordance with the simplified bill-
11 ing procedure referred to in subparagraph (b) and these
12 payments shall be treated as an administrative expense to the
13 medical insurance program: *Provided, however, That:*

14 “(A) not more than \$1 shall be payable to a phy-
15 sician for claims for services furnished to any par-
16 ticular patient within any seven-day period; and

17 “(B) no administrative cost-savings allowance
18 shall be payable for services performed for a hospital
19 inpatient or outpatient unless:

20 “(i) the services are surgical services, anes-
21 thesia services, or services performed by a physician
22 who, as an attending or consulting physician who,
23 has personally examined the patient and whose
24 office or regular place of practice is located outside
25 a hospital, and

1 “(ii) the physician ordinarily bills directly (and
2 not through such hospital) for his services;

1 the prevailing charge recognized by the carrier and found
2 acceptable by the Secretary for similar services in the same
3 locality in administering this part on December 31, 1970, or
4 (II) the prevailing charge level that, on the basis of statis-
5 tical data and methodology acceptable to the Secretary,
6 would cover 75 per centum of the customary charges made
7 for similar services in the same locality during the last pre-
8 ceding calendar year elapsing prior to the start of the fiscal
9 year in which the bill is submitted or the request for pay-
10 ment is made.

11 “(ii) In the case of physician services the prevailing
12 charge level determined for purposes of clause (i) (II) for
13 any fiscal year beginning after June 30, 1973, may not
14 (except as otherwise provided in clause (iii)) exceed (in
15 the aggregate) the level determined under such clause for
16 the fiscal year ending June 30, 1973, except to the extent
17 that the Secretary finds, on the basis of appropriate econom-
18 ics index data, that such higher level is justified by economic
19 changes. Moreover, for any fiscal year beginning after June
20 30, 1978, no prevailing charge level for physicians’ services
21 shall be increased to the extent that it would exceed by
22 more than one-third the statewide prevailing charge level
23 (as determined under subparagraph (E)) for that service.

24 “(iii) Notwithstanding the provisions of clauses (i) and
25 (ii) of this subparagraph, the prevailing charge level in the

1 case of a physician service in a particular locality determined
2 pursuant to such clauses for the fiscal year beginning July 1,
3 1975, shall, if lower than the prevailing charge level for the
4 fiscal year ending June 30, 1975, in the case of a similar
5 physician service in the same locality by reason of the appli-
6 cation of economic index data, be raised to such prevailing
7 charge level for the fiscal year ending June 30, 1975.

8 “(C) In the case of medical services, supplies, and
9 equipment (including equipment servicing) that, in the judg-
10 ment of the Secretary, do not generally vary significantly in
11 quality from one supplier to another, the charges incurred
12 after December 31, 1972, determined to be reasonable may
13 not exceed the lowest charge levels at which such services,
14 supplies, and equipment are widely and consistently available
15 in a locality except to the extent and under circumstances
16 specified by the Secretary.

17 “(D) The requirement in paragraph (3) (B) that a bill
18 be submitted or request for payment be made by the close of
19 the following calendar year shall not apply if (i) failure to
20 submit the bill or request the payment by the close of such
21 year is due to the error or misrepresentation of an officer,
22 employee, fiscal intermediary, carrier, or agent of the De-
23 partment of Health, Education, and Welfare performing
24 functions under this title and acting within the scope of his
25 or its authority, and (ii) the bill is submitted or the payment

1 is requested promptly after such error or misrepresentation
2 is eliminated or corrected.

3 “(E) The Secretary shall determine separate statewide
4 prevailing charge levels for each State that, on the basis of
5 statistical data and methodology acceptable to the Secretary,
6 would cover 50 percent of the customary charges made for
7 similar services in the State during the last preceding calen-
8 dar year elapsing prior to the start of the fiscal year in
9 which the bill is submitted or the request for payment is
10 made.

11 “(F) Notwithstanding any other provision of this para-
12 graph, any charge for any particular service or procedure
13 performed by a doctor of medicine or osteopathy shall be
14 regarded as a reasonable charge if—

15 “(i) the service or procedure is performed in an
16 area which the Secretary has designated as a physician
17 shortage area,

18 “the physician has a regular practice in the physi-
19 cian shortage area,

20 “(iii) the charge does not exceed the prevailing
21 charge level as determined under subparagraph (B),
22 and

23 “(iv) the charge does not exceed the physician’s
24 customary charge.”,

1 (2) The amendment made by paragraph (1) shall take
2 effect upon enactment.

3 HOSPITAL-ASSOCIATED PHYSICIANS

4 SEC. 12. (a) (1) Section 1861 (q) of the Social Se-
5 curity Act is amended by adding “(1)” immediately after
6 “(q)” and by adding, immediately before the period at the
7 end thereof, the following: “; except that the term does not
8 include any service that a physician may perform as an
9 educator, an executive, or a researcher; or any professional
10 patient care service unless the service (A) is personally
11 performed by or personally directed by a physician for the
12 benefit of the patient and (B) is of such nature that its
13 performance by a physician is customary and appropriate”.

14 (2) Section 1861 (q) is amended by adding the fol-
15 lowing paragraphs at the end:

16 “(2) In the case of anesthesiology services, a procedure
17 would be considered to be ‘personally performed’ in its en-
18 tirety by a physician where the physician performs the
19 following activities:

20 “(A) preanesthetic evaluation of the patient;

21 “(B) prescription of the anesthesia plan;

22 “(C) personal participation in the most demanding
23 procedures in this plan, including those of induction and
24 emergence and assuring that a qualified individual,
25 who need not be his employee, performs any of the

1 less demanding procedures which the physician does
2 not personally perform;

3 “(D) following the course of anesthesia adminis-
4 tration at frequent intervals;

5 “(E) remaining physically available for the im-
6 mediate diagnosis and treatment of emergencies; and

7 “(F) providing indicated postanesthesia care:

8 *Provided, however,* That during the performance of the activ-
9 ities described in subparagraphs (C), (D), and (E), the
10 physician is not responsible for the care of more than
11 one other patient. Where a physician performs the activities
12 described in subparagraphs (A), (B), (D), and (E) and
13 another individual performs the activities described in sub-
14 paragraph (C), the physician will be deemed to have
15 personally directed the services if he was responsible for no
16 more than four patients while performing the activities de-
17 scribed in subparagraphs (D) and (E) and the reasonable
18 charge for his personal direction shall not exceed one-half
19 the amount that would have been payable if he had person-
20 ally performed the procedure in its entirety.

21 “(3) Pathology services shall be considered ‘physicians’
22 services’ to patients only where the physician personally
23 performs acts or makes decisions with respect to a patient’s
24 diagnosis or treatment which require the exercise of medical
25 judgment. These include operating room and clinical con-

1 sultations, the required interpretation of the significance of
2 any material or data derived from a human being, the aspira-
3 tion or removal of marrow or other materials, and the ad-
4 ministration of test materials or isotopes. Such professional
5 services shall not include professional services such as: the
6 performance of autopsies; and services performed in carrying
7 out responsibilities for supervision, quality control, and for
8 various other aspects of a clinical laboratory's operations
9 that are customarily performed by nonphysician personnel.

10 (3) Section 1861 (b) of such Act is amended—

11 (A) by striking out “or” at the end of paragraph
12 (6),

13 (B) by striking out the period at the end of para-
14 graph (7) and inserting “; or”, and

15 (C) by adding at the end the following paragraph:

16 “(8) a physician, if the services provided are not
17 physicians' services (within the meaning of subsection
18 (q)) .”.

19 (b) (1) Section 1861 (s) of the Social Security Act
20 is amended by adding at the end: “The term ‘medical and
21 other health services’ shall not include services described in
22 paragraphs (2) (A) and (3) if furnished to inpatients of a
23 provider of services unless the Secretary finds that, because
24 of the size of the hospital and the part-time nature of the
25 services or for some other reason acceptable to him, it would

1 be less efficient to have the services furnished by the hospital
2 (or by others under arrangement with them made by the
3 hospital) than to have them furnished by another party.”.

4 (2) Section 1842 (b) (3A) of such Act, as added by
5 section 20 of this Act, is amended by adding:

6 “(G) The charge for a physician’s or other per-
7 son’s services and items which are related to the income
8 or receipts of a hospital or hospital subdivision shall not
9 be considered in determining his customary charge to
10 the extent that the charge exceeds an amount equal to
11 the salary which would reasonably have been paid for
12 the service (together with any additional costs that
13 would have been incurred by the hospital) to the physi-
14 cian performing it if it had been performed in an employ-
15 ment relationship with the hospital plus the cost of other
16 expenses (including a reasonable allowance for travel-
17 time and other reasonable types of expense related to
18 any differences in acceptable methods of organization
19 for the provision of services) incurred by the physician,
20 as the Secretary may determine to be appropriate.”.

21 (c) Section 1861 (v) of the Social Security Act is
22 amended by adding:

23 “(8) (A) Where physicians’ services are furnished
24 under an arrangement (including an arrangement under
25 which the physician performing the services is compensated

1 on a basis related to the amount of the income or receipts of
2 the hospital or any department or other subdivision) with
3 a hospital or medical school, the amount included in any
4 payment to the hospital under this title as the reasonable
5 cost of the services (as furnished under the arrangement)
6 shall not exceed an amount equal to the salary which would
7 reasonably have been paid for the services (together with
8 any additional costs that would have been incurred by the
9 hospital) to the physician performing them if they had
10 been performed in an employment relationship with the
11 hospital (rather than under such arrangement) plus the
12 cost of other expenses (including a reasonable allowance for
13 traveltime and other reasonable types of expense related to
14 any differences in acceptable methods of organization for the
15 provision of the services) incurred by the physician, as the
16 Secretary may determine to be appropriate.”.

17 (d) (1) Section 1833 (a) (1) (B) of the Social Secu-
18 rity Act is amended by inserting “(except as provided in
19 subsection (h)) ” immediately after “amounts paid shall”.

20 (2) Section 1833 (b) (2) of such Act is amended by
21 inserting “(except as otherwise provided in subsection
22 (h)) ” immediately after “amount paid shall”.

23 (3) Section 1833 of such Act is amended by adding:
24 “(h) The provisions of subsection (a) (1) (B) and
25 clause (2) of the first sentence of subsection (b) shall not

1 apply to any physician unless he has entered into an
 2 agreement with the Secretary under which he agrees to be
 3 compensated for all such services on the basis of an assign-
 4 ment the terms of which are described in section 1842 (b)
 5 (3) (B) (ii).”.

6 (e) The amendments made by this section shall, except
 7 those made by subsection (d), apply to services furnished
 8 in accounting periods of the hospital which begin after the
 9 month following the month of enactment of this Act. The
 10 amendment made by subsection (d) shall be effective July
 11 1, 1978.

12 PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF
 13 MEDICARE

14 SEC. 13. (a) Section 1861 (s) (2) of the Social Security
 15 Act is amended—

16 (1) by striking out “and” at the end of clause
 17 (C),

18 (2) by inserting “and” at the end of clause (D),
 19 and

20 (3) by adding after clause (D) the following new
 21 clause:

22 “(E) antigens (subject to reasonable quantity lim-
 23 itations determined by the Secretary) prepared by an
 24 allergist for a particular patient, including antigens he
 25 prepares which are forwarded to another qualified per-

1 son for administration to the patient by or under the
2 supervision of another physician;”.

3 (b) Subsection (a) shall apply to items furnished after
4 the month of enactment of this Act.

5 PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS’
6 FEES ON ACCOUNT OF SERVICES FURNISHED TO A
7 DECEASED INDIVIDUAL

8 SEC. 14. (a) Section 1870 (f) of the Social Security
9 Act is amended, in the matter following clause (2) thereof,
10 by—

11 (1) inserting “(A)” immediately after “, and only
12 if”, and

13 (2) by inserting immediately before the period the
14 following: “, or (B) the spouse or other legally desig-
15 nated representative of such individual requests (in
16 such form and manner as the Secretary shall by regula-
17 tions prescribe) that payment for such services without
18 regard to clause (A)”.

19 (b) Subsection (a) shall apply to payments made after
20 the month of enactment.

21 USE OF APPROVED RELATIVE VALUE SCHEDULE

22 SEC. 15. (a) To provide common language describing
23 the various kinds and levels of medical services which may
24 be reimbursed under titles V, XVIII, and XIX, of the Social
25 Security Act, the Secretary of Health, Education, and Wel-

1 fare shall establish a system of procedural terminology, in-
2 cluding definitions of the terms. The system shall be de-
3 veloped by the Health Care Financing Administration with
4 the advice of other large health care purchasers, representa-
5 tives of professional groups and other interested parties.
6 In developing the system, the Health Care Financing
7 Administration shall consider among other things, the
8 experience of third parties in using existing terminology
9 systems in terms of: implications for administrative and
10 program costs; simplicity and lack of ambiguity; and the
11 degree of acceptance and use.

12 (b) Upon development of a proposed system of proce-
13 dural terminology and its approval by the Secretary of
14 Health, Education, and Welfare, it shall be published in
15 the Federal Register. Interested parties shall have not less
16 than six months in which to comment on the proposed sys-
17 tem and to recommend relative values to the Secretary for
18 the procedures and services designated by the terms. Com-
19 ments and proposals shall be supported by information and
20 documentation specified by the Secretary.

21 (c) The good faith preparation of a relative value sched-
22 ule or its submission to the Secretary by an association of
23 health practitioners solely in response to a request of the
24 Secretary as authorized under this section shall not in itself
25 be considered a violation of any consent decree by which

1 an association has waived its right to make recommendations
2 concerning fees: *Provided*, That the proposed relative value
3 schedule shall not be disclosed to anyone other than those
4 persons actually preparing it or their counsel until it is made
5 public by the Secretary.

6 (d) The Health Care Financing Administration shall
7 review materials submitted under this section and shall
8 recommend that the Secretary adopt a specific terminology
9 system and its relative values for use by carriers in calculat-
10 ing reasonable charges under title XVIII of the Social
11 Security Act, but only after:

12 (1) Interested parties have been given an oppor-
13 tunity to comment and any comments have been
14 considered;

15 (2) Statistical analyses have been conducted assess-
16 ing the economic impact of the relative values on the
17 physicians in various specialties, geographic areas and
18 types of practice, and on the potential liability of the
19 program established by part B of title XVIII of the
20 Social Security Act;

21 (3) It has been determined that the proposed ter-
22 minology and related definitions are unambiguous, prac-
23 tical, and easy to evaluate in actual clinical situations
24 and that the unit values assigned generally reflect the

1 relative time and effort required to perform various
2 procedures and services.

3 (4) That the use of the proposed system will en-
4 hance the administration of the Federal health care
5 financing programs.

6 (e) A system of terminology, definitions, and their
7 relative values, as approved by the Secretary, shall be pe-
8 riodically reviewed by him and may be modified. An ap-
9 proved system (as amended by any modification of the
10 Secretary) may subsequently be used by any organization
11 or person for purposes other than those of this Act. Nothing
12 in this section shall be considered to bar the Secretary from
13 adopting a uniform system of procedural terminology in
14 situations where a relative value schedule has not been
15 approved.

16 HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

17 SEC. 20. (a) Section 1861 of the Social Security Act
18 is amended by adding after subsection (aa) (as added by
19 section 10 (b) of this Act) the following:

20 "Hospital Providers of Extended Care Services

21 "(bb) (1) (A) Any hospital (other than a hospital
22 which has in effect a waiver of the requirement imposed by
23 subsection (e) (5)) which has an agreement under section
24 1866 may (subject to paragraph (2)) enter into an agree-
25 ment with the Secretary under which its inpatient hospital

1 facilities may be used for the furnishing of services of the
2 type which, if furnished by a skilled nursing facility, would
3 constitute post-hospital extended care services.

4 “(B) (i) Notwithstanding any other provision of this
5 title, payment to any hospital for services furnished under
6 an agreement entered into under this subsection shall be
7 based upon the reasonable cost of the services as determined
8 under this subparagraph.

9 “(ii) The reasonable cost of the services will consist of
10 the reasonable cost of routine services and ancillary services.
11 The reasonable cost of routine services furnished during any
12 calendar year by a hospital under an agreement under this
13 subsection shall equal the product of the number of patient-
14 days during the year for which the services were furnished
15 and the average reasonable cost per patient-day. The aver-
16 age reasonable cost per patient-day shall be established as
17 the average rate per patient-day paid for routine services
18 during the previous calendar year under title XIX to skilled
19 nursing facilities located in the State in which the hospital is
20 located and which have agreements entered into under sec-
21 tion 1902a (28). The reasonable cost of ancillary services
22 shall be determined in the same manner as the reasonable
23 cost of ancillary services provided for inpatient hospital
24 services.

1 “(2) (A) The Secretary shall not enter into an agree-
2 ment under this subsection with any hospital unless—

3 “(i) for a period specified by the Secretary (not
4 less than twelve months) which immediately precedes
5 the date the agreement is entered into, the hospital has
6 had an average daily occupancy rate of less than 60
7 percent,

8 “(ii) the hospital is located in a rural area and has
9 less than 50 beds, and

10 “(iii) the hospital has been granted a certificate
11 of need for the provision of long-term care services
12 from the agency of the State (which has been desig-
13 nated as the State health planning and development
14 agency under an agreement pursuant to section 1521
15 of the Public Health Service Act) in which the hospital
16 is located.

17 “(3) An agreement with a hospital entered into under
18 this section shall, except as otherwise provided under reg-
19 ulations of the Secretary, be of the same duration and
20 subject to termination on the same conditions as are agree-
21 ments with skilled nursing facilities under section 1866,
22 unless the hospital fails to satisfy the requirements defined
23 in paragraph (2) (A) of this subsection and shall, where not
24 inconsistent with any provision of this subsection, impose
25 the same duties, responsibilities, conditions, and limitations,

1 as those imposed under such agreements entered into under
2 section 1866; except that no such agreement with any hos-
3 pital shall be in effect for any period during which the hos-
4 pital does not have in effect an agreement under section
5 1866, or where there is in effect for the hospital a waiver of
6 the requirement imposed by subsection (e) (5). A hospital
7 whose agreement has been terminated shall not be eligible
8 to undertake a new agreement until a two-year period has
9 elapsed from the termination date.

10 “(4) Any agreement with a hospital under this sub-
11 section shall provide that payment for services will be made
12 only for services for which payment would be made as post-
13 hospital extended care services, if those services had been
14 furnished by a skilled nursing facility under an agreement
15 entered into under section 1866; and any individual who is
16 furnished services, for which payment may be made under an
17 agreement, shall, for purposes of this title (other than this
18 subsection), be deemed to have received post-hospital ex-
19 tended care services in like manner and to the same extent
20 as if the services furnished to him had been post-hospital
21 extended care services furnished by a skilled nursing facility
22 under an agreement under section 1866.

23 “(5) During a period for which a hospital has in effect
24 an agreement under this subsection, in order to allocate rou-
25 tine costs between hospital and long-term care services for

1 purposes of determining payment for inpatient hospital serv-
2 ices (including the application of reimbursement limits speci-
3 fied in section 1861 (aa)), the total reimbursement received
4 for routine services from all classes of long-term care patients,
5 including title XVIII, title XIX, and private pay patients,
6 shall be subtracted from the hospital's total routine costs
7 before calculations are made to determine title XVIII reim-
8 bursement for routine hospital services.

9 “(6) During any period during which an agreement is
10 in effect with a hospital under this subsection, the hospital
11 shall, for services furnished by it under the agreement, be
12 considered to satisfy the requirements, otherwise required, of
13 a skilled nursing facility for purposes of the following pro-
14 visions: sections 1814 (a) (2) (C), 1814 (a) (6), 1814 (a)
15 (7), 1814 (h), 1861 (a) (2), 1861 (i), 1861 (j) (except
16 1861 (j) (12)), and 1861 (n) ; and the Secretary shall
17 specify any other provisions of this Act where the hospital
18 may be considered as a skilled nursing facility.

19 “(7) (c) Within three years after enactment, the Secre-
20 tary shall provide a report to the Congress containing an
21 evaluation of the program established under this subsection
22 concerning:

23 “(1) The extent and effect of the agreements on
24 availability and effective and economical provision of
25 long-term care services,

1 “(2) whether the program should be continued,
2 and

3 “(3) whether eligibility should be extended to
4 other hospitals, regardless of bed size or geographic lo-
5 cation, where there is a shortage of long-term care
6 beds.”.

7 (b) Title XIX of such Act is amended by adding at
8 the end thereof the following new section:

9 “HOSPITAL PROVIDERS OF SKILLED NURSING AND INTER-
10 MEDIATE CARE SERVICES

11 “SEC. 1911. (a) Notwithstanding any other provision
12 of this title, payment may be made, in accordance with
13 this section, under an approved State plan for skilled nurs-
14 ing services and intermediate care services furnished by a
15 hospital which has in effect an agreement under section
16 1861 (bb).

17 “(b) (1) Payment to any such hospital, for any skilled
18 nursing or intermediate care services furnished, shall be at a
19 rate equal to the average rate per patient-pay paid for routine
20 services during the previous calendar year under this title
21 to skilled nursing and intermediate care facilities located in
22 the State in which the hospital is located. The reasonable
23 cost of ancillary services shall be determined in the same
24 manner as the reasonable cost of ancillary services provided
25 for inpatient hospital service

1 “(2) With respect to any period for which a hospital
 2 has an agreement under section 1861 (bb), in order to allo-
 3 cate routine costs between hospital and long-term care serv-
 4 ices, the total reimbursement for routine services received
 5 from all classes of long-term care patients, including title
 6 XVIII, title XIX, and private pay patients, shall be sub-
 7 tracted from the hospital total routine costs before calcula-
 8 tions are made to determine title XIX reimbursement for
 9 routine hospital services.”.

10 (c) The amendments made by this section shall be-
 11 come effective on the date on which final regulations, promul-
 12 gated by the Secretary to implement the amendments, are
 13 issued; and those regulations shall be issued not later than
 14 the first day of the sixth calendar month following the month
 15 in which this Act is enacted.

16 REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED
 17 NURSING AND INTERMEDIATE CARE FACILITIES

18 SEC. 21. Section 1902 (a) (13) (E) of the Social Se-
 19 curity Act is amended by inserting “(and which may, at the
 20 option of the State, include a reasonable profit for the facil-
 21 ity in the form of: (a) fixed per diem amounts or, (b)
 22 incentive payments related to efficient performance, or (c)
 23 a rate of return on net equity)” immediately after “cost
 24 related basis”.

1 MEDICAID CERTIFICATION AND APPROVAL OF SKILLED
2 NURSING AND INTERMEDIATE CARE FACILITIES

3 SEC. 22. (a) Section 1910 of the Social Security Act is
4 amended to read:

5 "CERTIFICATION AND APPROVAL OF SKILLED NURSING AND
6 INTERMEDIATE CARE FACILITIES

7 "SEC. 1910. (a) The Secretary shall make an agree-
8 ment with any State which is willing and able to do so
9 whereby the State health agency or other appropriate State
10 or local agencies (whichever are utilized by the Secretary
11 pursuant to section 1864 (a)) will be utilized to recommend
12 to him whether an institution in the State qualifies as a
13 skilled nursing facility (for purposes of section 1902 (a)
14 (28)) or an intermediate care facility (for purposes of sec-
15 tion 1905 (c)).

16 "(b) The Secretary shall advise the State agency ad-
17 ministering the medical assistance plan of his approval or
18 disapproval of any institution certified to him as a qualified
19 skilled nursing or intermediate care facility for purposes of
20 section 1902 (a) (28) and specify for each institution the
21 period (not to exceed twelve months) for which approval is
22 granted, except that the Secretary may extend that term
23 for up to two months, where the health and safety of patients
24 will not be jeopardized, if he finds that an extension is
25 necessary to prevent irreparable harm to the facility or

1 hardship to the facility's patients or if he finds it impracticable within the twelve-month period to determine whether
2 the facility is complying with the provisions of this title and
3 applicable regulations. The State agency may upon approval
4 of the Secretary enter into an agreement with any skilled
5 nursing or intermediate care facility for the specified approval
6 period.

8 “(c) The Secretary may cancel approval of any skilled
9 nursing or intermediate care facility at any time if he finds
10 that a facility fails to meet the requirements contained in
11 section 1902 (a) (28) or section 1905 (c), or if he finds
12 grounds for termination of his agreement with the facility
13 pursuant to section 1866 (b). In that event the Secretary
14 shall notify the State agency and the skilled nursing or intermediate care facility that approval of eligibility of the facility
15 to participate in the programs established by this title and
16 title XVIII shall be terminated at a time specified by the
17 Secretary. The approval of eligibility of any such facility to
18 participate in the programs may not be reinstated unless the
19 Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not
20 recur.

23 “(d) Effective July 1, 1978, no payment may be made
24 to any State under this title for skilled nursing or intermediate care facility services furnished by any facility—

1 “(1) which does not have in effect an agreement
2 with the State agency pursuant to subsection (b), or

3 “(2) whose approval of eligibility to participate in
4 the programs established by this title or title XVIII
5 has been terminated by the Secretary and has not been
6 reinstated, except that payment may be made for up to
7 thirty days for skilled nursing or intermediate care fa-
8 cility services furnished to any eligible individual who
9 was admitted to the facility prior to the effective date of
10 the termination.”.

11 “(e) Any skilled nursing facility or intermediate care
12 facility which is dissatisfied with any determination by the
13 Secretary that it no longer qualifies as a skilled nursing
14 facility or intermediate care facility for purposes of this
15 title shall be entitled to a hearing by the Secretary to the
16 same extent as is provided in section 205 (b) and to judicial
17 review of the Secretary’s final decision after such hearing as
18 is provided in section 205 (g) . Any agreement between such
19 facility and the State agency shall remain in effect until the
20 period for filing a request for a hearing has expired or, if a
21 request has been filed, until a decision has been made by the
22 Secretary: *Provided, however,* That the agreement shall
23 not be extended if the Secretary makes a written determina-
24 tion, specifying the reasons therefor, that the continuation
25 of provider status constitutes an immediate and serious

1 threat to the health and safety of patients, and if the Secre-
2 tary certifies that the facility has been notified of its defi-
3 ciencies and has failed to correct them.”.

4 (b) Section 1869 (c) of the Social Security Act is
5 amended by adding at the end the following sentence: “If
6 the Secretary’s determination terminates a provider with an
7 existing agreement pursuant to section 1866 (b) (2) , or if
8 that determination consists of a refusal to renew an existing
9 provider agreement, the provider’s agreement shall remain in
10 effect until the period for filing a request for a hearing has
11 expired or, if a request has been filed, until a final decision
12 has been made by the Secretary: *Provided, however, That*
13 the agreement shall not be extended if the Secretary makes a
14 written determination, specifying the reasons therefor, that
15 the continuation of provider status constitutes an immediate
16 and serious threat to the health and safety of patients and if
17 the Secretary certifies that the provider has been notified
18 of such deficiencies and has failed to correct them.”.

19 (c) The amendments made by this section shall be-
20 come effective on the date on which final regulations, promul-
21 gated by the Secretary to implement the amendments, are
22 issued; and those regulations shall be issued not later than

1 the first day of the sixth calendar month following the month
2 in which this Act is enacted.

3 VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED
4 NURSING OR INTERMEDIATE CARE FACILITIES

5 SEC. 23. Section 1903 of the Social Security Act is
6 amended by adding:

7 “(1) In the administration of this title, the fact that an
8 individual who is an inpatient of a skilled nursing or inter-
9 mediate care facility leaves to make visits outside the facility
10 shall not conclusively indicate that he does not need services
11 which the facility is designed to provide; however, the fre-
12 quency and length of visits away shall be considered, to-
13 gether with other evidence, in determining whether the in-
14 dividual is in need of the facility’s services.”

15 ESTABLISHMENT OF HEALTH CARE FINANCING

16 ADMINISTRATION

17 SEC. 30. (a) Section 702 of the Social Security Act is
18 amended—

19 (1) by inserting “(a)” immediately after “SEC.
20 702.”, and

21 (2) by adding at the end the following subsection:

22 “(b) The Secretary shall establish, within the De-
23 partment of Health, Education, and Welfare, a separate
24 organization to be known as the Health Care Financing
25 Administration (which shall include the functions and per-

1 sonnel of administrative entities known as of January 1, 1977
2 as the 'Bureau of Health Insurance', the 'Medical Services
3 Administration', the 'Bureau of Quality Assurance' (includ-
4 ing the National Professional Standards Review Council),
5 and the 'Office of Long-Term Care' and related research
6 and statistical units (including the Division of Health In-
7 surance Studies of the Social Security Administration)
8 which shall be under the direction of the Assistant Secre-
9 tary for Health Care Financing, who shall report directly
10 to the Secretary and who shall have policy and adminis-
11 trative responsibility (including policy and administrative
12 responsibility with respect to health care standards and certi-
13 fication requirements as they apply to practitioners and in-
14 stitutions) for the programs established by titles XVIII
15 and XIX, part B of title XI, for the renal disease program
16 established by section 226 and any other health care financ-
17 ing programs as may be established under this Act. The
18 Assistant Secretary may not have any other duties or func-
19 tions assigned to him which would prevent him from carrying
20 out the duties required under the preceding sentence on a full-
21 time basis.

22 (b) (1) There shall be in the Department of Health,
23 Education, and Welfare an Assistant Secretary for Health
24 Care Financing, who shall be appointed by the President,
25 by and with the advice and consent of the Senate.

1 (2) Section 5315 of title 5, United States Code, is
2 amended in paragraph (17) by striking out "(5)" and
3 inserting in lieu thereof "(6)".

4 STATE MEDICAID ADMINISTRATION

5 SEC. 31. (a) Section 1902 (a) is amended by adding at
6 the end the following:

7 "(37) provide—

8 "(A) for making eligibility determinations on
9 the basis of applications for coverage, within forty-
10 five days of the date of application for all individ-
11 uals: (i) receiving aid or assistance (or who ex-
12 cept for income and resources would be eligible for
13 aid or assistance) under a plan of the State ap-
14 proved under title IV, part A, (ii) receiving aid or
15 assistance (or who except for income and resources
16 would be eligible for assistance) under any plan
17 of the State approved under title I, X, or XVI
18 (for the aged and the blind), or (iii) with respect
19 to whom supplemental security income benefits are
20 being paid (or who would except for income and
21 resources be eligible to have paid with respect to
22 them supplemental security income benefits) under
23 title XVI on the basis of age or blindness; and

24 "(B) for making eligibility determina-

1 tions based upon applications for coverage, within
2 sixty days of application for all individuals;
3 (i) receiving aid or assistance (or who except for
4 income and resources would be eligible for aid or
5 assistance) on the basis of disability under any plan
6 of the State approved under title XIV or XVI, or
7 (ii) for whom supplemental security income bene-
8 fits are being paid (or who would except for income
9 and resources be eligible to have paid to them
10 supplemental security income benefits) under title
11 XVI based upon disability;

12 “(C) for making redeterminations of eligi-
13 bility for persons specified in subparagraphs
14 (A) and (B): (i) when required based upon
15 information the agency has previously obtained on
16 anticipated changes in the individual’s situation, (ii)
17 within thirty days after receiving information on
18 changes in an individual’s circumstances which may
19 affect his eligibility, and (iii) periodically but not
20 less often than every six months for persons speci-
21 fied in subparagraph (A) (i), and not less often
22 than annually for persons specified in subparagraph
23 (A) (ii) and (A) (iii);

24 “(38) establish procedures to assure accurate
25 determinations of eligibility and provide that the error

rate for eligibility determinations made on or after October 1, 1977, shall not exceed the rate specified in section 1911 (b) ; and

“(39) establish payment procedures to assure that (A) 95 percent of claims for which no further written information or substantiation is required to make payment, be paid within thirty days of receipt of the claim from a provider, and that 99 percent of such claims be paid within ninety days, and (B) both prepayment and postpayment claims review procedures are performed, including—

“(i) review, on a reasonable sample or more extensive basis, to determine the accuracy of data submitted and processed;

“(ii) review to determine that the provider is a participating provider;

“(iii) review to determine whether the service is covered under the State’s plan;

“(iv) review to determine whether the recipient is eligible;

“(v) review of care and services provided where such review has not been assumed by an organization designated by the Secretary under part B of title XI of this Act;

1 “(vi) review to determine that payments made
2 do not exceed those allowable;

3 “(vii) review to determine and recover any
4 third party liability;

5 “(viii) review which reasonably safeguards
6 against duplicate billing.”.

7 (b) Section 1902 (a) (6) is amended by adding the
8 following at the end: “the reports are to be accurate and
9 filed within sixty days following the close of the reporting
10 period for monthly and quarterly reports, and within one
11 hundred and five days following the close of reporting
12 periods for yearly reports;”.

13 (c) Amend section 1903 by adding at the end the
14 following subsection:

15 “(n) (1) Effective with each calendar quarter beginning
16 October 1, 1978 the amount paid to each State under para-
17 graphs (a) (2), (a) (3), and (a) (6) shall be reduced or
18 terminated unless the State demonstrates to the Secretary
19 that—

20 “(A) 95 percent of eligibility determinations are
21 made within the time periods specified under section
22 1902 (a) (37) (A) and (B), except that in determin-
23 ing whether a State has met the requirements of this
24 paragraph there shall not be included eligibility deter-
25 minations for persons whose eligibility is determined

1 under State plans approved under title I, X, XIV; XVI,
2 or part A of title IV, or by the Secretary under sec-
3 tion 1634;

4 “(B) the State’s eligibility determination error rate
5 does not exceed the rate specified in section 1911 (b),
6 except that in determining whether a State has met the
7 requirements of this paragraph there shall not be
8 included error rates for those persons whose eligi-
9 bility is determined under a State plan approved under
10 titles I, X, XIV, XVI, or part A of title IV or by
11 the Secretary under section 1634;

12 “(C) the State is processing claims for payment
13 within the time period specified in section 1902 (a)
14 (39) (A) and applying prepayment and postpayment
15 claims review procedures specified in section 1902 (a)
16 (39) (B) ; and

17 “(D) the State is making timely and complete
18 reports to the Secretary on the operation of its medi-
19 cal assistance program within the time period includ-
20 ing the information specified in section 1902 (a) (6).

21 “(2) The Secretary shall conduct an onsite survey in
22 each State, at least annually, of State performance in each
23 category under paragraph (1). The methodology and pro-
24 cedures (which may involve onsite evaluation) employed,
25 including procedures for any necessary followup of any de-

1 deficiencies, must be formally approved by the Comptroller
2 General of the United States;

3 “(3) Any State which fails to meet one or more of the
4 requirements specified in subparagraph (A), (B), (C)
5 or (D) of paragraph (1) shall be formally notified within
6 thirty days of the survey of the deficiencies. The State shall
7 be given an appropriate period of time, not to exceed six
8 months, to correct the deficiencies;

9 “(4) Any State which fails to correct deficiencies within
10 the time period specified under paragraph (3) as determined
11 by the Secretary shall be notified and subject to a reduction
12 in Federal matching as specified in paragraph (5) beginning
13 on the first day of the first calendar quarter following the
14 date on which the Secretary specified the deficiencies must be
15 corrected under paragraph (3);

16 “(5) (A) Where the Secretary finds that a State failed
17 to meet the requirements of one of the subparagraphs (A),
18 (B), (C), or (D) of paragraph (1) and has not made cor-
19 rections required under paragraph (4), Federal matching
20 shall be reduced to 50 percent of what the State would other-
21 wise receive under subsections (a) (2), (a) (3), and (a)
22 (6).

23 “(B) Where the Secretary determines that a State fail-
24 ed to meet requirements of two or more of subparagraphs
25 (A), (B), (C), or (D) of paragraph (1) and that it has

1 not made the corrections as determined under paragraph
2 (4), its Federal matching shall be terminated under sub-
3 sections (a) (2), (a) (3), and (a) (6).

4 “(6) (A) Any State which had had Federal matching
5 reduced or terminated under paragraph (5) shall continue to
6 have the matching reduced or terminated until the Secretary
7 determines that the deficiencies have been corrected.

8 “(B) A State determined to have corrected all cate-
9 gories specified as deficient shall be entitled to the matching
10 rate specified in subsections (a) (2), (a) (3), and (a) (6)
11 beginning on the first day of the calendar quarter in which
12 the corrections were made.

13 “(C) In a State where matching has been terminated
14 under subsections (a) (2), (a) (3), and (a) (6) as pro-
15 vided under subparagraph (5) (B) and where the Secretary
16 determines that deficiencies continue in only one of the four
17 specified categories, that State shall, beginning on the first
18 day of the calendar quarter in which the correction was
19 made, be entitled to the reduced matching rate specified in
20 subparagraph (5) (A).

21 “(7) Where a State is determined by the Secretary
22 based upon an onsite evaluation to substantially exceed the
23 requirements of at least two of subparagraphs (A), (B),
24 (C), or (D) of paragraph (1) and meets the requirements
25 of the remaining subparagraphs, that State shall be notified

1 and entitled to a Federal matching rate under subsection
2 (a) (6) of 75 percent and that amount shall apply in each
3 calendar quarter for which the Secretary finds the State con-
4 tinues to meet the requirements of this paragraph;

5 “(8) The Secretary shall provide or arrange for the
6 reasonable provision of technical assistance by experienced
7 and qualified Federal, State, or local governmental person-
8 nel to any State which requests assistance in meeting the
9 requirements of paragraph (1).

10 “(9) If the Secretary notifies a State of deficiencies, or
11 a reduction, termination, or increase in Federal matching,
12 simultaneous notification shall also be made to the Governor
13 of the State, and the respective chairmen of the legislative
14 and appropriation committees of that State’s legislature
15 having jurisdiction over the medical assistance program
16 authorized under this title.”.

17 (d) Title XIX of the Social Security Act is amended by
18 adding at the end the following new sections:

19 “QUALITY CONTROL

20 “SEC. 1911. The Secretary shall—

21 “(a) determine the eligibility error rates, including
22 cases incorrectly approved and cases incorrectly denied,
23 for each State for the six-month period commencing
24 with the first calendar quarter beginning six months
25 following enactment of this title. The Secretary shall

1 exclude those cases for which the most recent determina-
2 tion or redetermination of eligibility was correctly
3 made, but where eligibility status subsequently changed,
4 if the State meets the time requirements specified in
5 section 1902 (a) (37) ;

6 “(b) establish a State classification system, with
7 States classified according to: (1) whether the State
8 provides medical assistance for persons specified in sec-
9 tion 1902 (a) (10) (C) ; and (2) population, with those
10 States with greater populations in one grouping and
11 those States with lesser populations in another;

12 “(c) establish an error rate defined as the rate
13 which equals the 75th percentile of the rates reported
14 by the States under paragraph (a) for each class of
15 States under (b) .

16 “REPORT BY THE SECRETARY

17 “SEC. 1912. The Secretary shall prepare a biannual
18 report (beginning with fiscal year 1978) on the character-
19 istics of the State programs of medical assistance financed
20 under this title, including, at least (1) a description of the
21 scope and duration of benefits available in each State, (2) a
22 description of eligibility criteria for all groups eligible for
23 medical assistance, (3) specification of the reimbursement
24 methodology for payments under the State program for the
25 major types of services, and (4) a listing of all fiscal agents,

1 insurers and health maintenance organizations contracted
2 with for administration of the program. Such report shall be
3 submitted to the Committee on Finance of the Senate and
4 the Committee on Interstate and Foreign Commerce of the
5 House of Representatives no later than six months following
6 the close of the fiscal year."

7 REGULATIONS OF THE SECRETARY

8 SEC. 32. (a) (1) Section 1102 of the Social Security
9 Act is amended—

10 (A) by inserting "(a)" immediately after "SEC.
11 1102.", and

12 (B) by adding at the end the following subsection:

13 "(b) Whenever the Secretary, in compliance with
14 requirements imposed by law, has published in the Federal
15 Register general notice of any proposed rule or regulation
16 to be promulgated by him, that notice shall indicate whether
17 prompt promulgation is urgent. Where the notice indicates
18 that prompt promulgation is urgent, the rule or regulation
19 shall become effective within sixty days after publication of
20 the notice; in any other case, the rule or regulation shall
21 become effective without regard to the provisions of this
22 subsection in the manner prescribed by applicable provisions
23 of law."

24 (2) Amendments made by paragraph (1) shall be
25 effective for proposed rules published in the Federal Register

1 on and after the first day of the first calendar month which
 2 begins more than thirty days after the date of enactment of
 3 this Act.

4 (b) Except as otherwise specified in this Act or
 5 in a provision of law which is enacted or amended by
 6 this Act, any regulation of the Secretary of Health, Educa-
 7 tion, and Welfare (hereinafter in this section referred to as
 8 the "Secretary"), which is necessary or appropriate to im-
 9 plement any provision of this Act or any other provision of
 10 law which is enacted or modified by this Act, shall, subject
 11 to paragraph (2), be promulgated so as to become effective
 12 not later than the first day of the thirteenth month following
 13 the month in which this Act is enacted.

14 REPEAL OF SECTION 1867

15 SEC. 33. Section 1867 of the Social Security Act is
 16 hereby repealed.

17 PROCEDURES FOR DETERMINING REASONABLE COST AND 18 REASONABLE CHARGE

19 SEC. 40. (a) (1) In determining the amount of any
 20 payment under title XVIII, under a program established
 21 under title V, or under a State plan approved under title
 22 XIX, when the payment is based upon the reasonable cost
 23 or reasonable charge, no element comprising any part of
 24 the cost or charge shall be considered to be reasonable if, and
 25 to the extent that, that element is—

1 (A) a commission, finder's fee, or for a similar
2 arrangement, or

3 (B) an amount payable for any facility (or part
4 or activity thereof) under any rental or lease arrange-
5 ment

6 which is, directly or indirectly, determined, wholly or in
7 part as a percentage, fraction, or portion of the charge or
8 cost attributed to any health service (other than the ele-
9 ment) or any health service including, but not limited to,
10 the element.

11 AMBULANCE SERVICE

12 SEC. 41. (a) Section 1861 (s) (7) of the Social Security
13 Act is amended by inserting:

14 “(Including ambulance service to the nearest hos-
15 pital which is: (a) adequately equipped and (b) has
16 medical personnel qualified to deal with, and available
17 for the treatment of, the individual's illness, injury, or
18 condition)” immediately after “ambulance service”.

19 (b) The amendment made by subsection (a) shall
20 apply to services furnished on and after the first day of the
21 first calendar month which begins after the date of enact-
22 ment of this Act.

23 GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

24 SEC. 42. (a) Section 511 of the Social Security Act is
25 amended—

1 (1) by inserting “(a)” immediately after “SEC.
2 511.”, and

3 (2) by adding at the end of the section:

4 “(b) (1) From the sums available under paragraph
5 (2), the Secretary is authorized to make grants to public
6 or nonprofit private regional pediatric respiratory centers,
7 which are a part of (or are affiliated with) an institution of
8 higher learning, to assist them in carrying out a program for
9 the training and instruction (through demonstrations and
10 otherwise) of health care personnel in the prevention, diag-
11 nosis and treatment of respiratory diseases in children and
12 young adults, and in providing (through such program)
13 needed health care services to children and young adults
14 suffering from such diseases.

15 “(2) For the purpose of making grants under this sub-
16 section, there is authorized to be appropriated, for the fiscal
17 year ending September 30, 1978, and each of the next four
18 succeeding fiscal years, such sums (not in excess of \$5,-
19 000,000 for any fiscal year) as may be necessary. Sums
20 authorized to be appropriated for any fiscal year under this
21 subsection for making grants for the purposes referred to in
22 paragraph (1) shall be in addition to any sums authorized
23 to be appropriated for such fiscal year for similar purposes
24 under other provisions of this title.”.

25 (b) Section 502 (2) of such Act is amended by insert-
26 ing “(a)” immediately after “511”.

1 WAIVER OF HUMAN EXPERIMENTATION PROVISION
 2 FOR MEDICARE AND MEDICAID

3 SEC. 43. Any requirements of title II of Public Law
 4 93-348 otherwise held applicable are hereby waived with
 5 respect to programs established under titles XVIII and XIX
 6 of the Social Security Act.

7 DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

8 SEC. 44. Section 1106 of the Social Security Act is
 9 amended by adding:

10 “(f) The Secretary shall not make available, nor shall
 11 the State title XIX agency be required to make available
 12 to the public information relating to the amounts that have
 13 been paid to individual doctors of medicine or osteopathy
 14 by or on behalf of beneficiaries of the health programs estab-
 15 lished by titles XVIII or XIX, as the case may be, except
 16 as may be necessary to carry out the purposes of those titles
 17 or as may be specifically required by the provisions of other
 18 Federal law.”.

19 RESOURCES OF MEDICAID APPLICANT TO INCLUDE CERTAIN
 20 PROPERTY PREVIOUSLY DISPOSED OF TO APPLICANT'S
 21 RELATIVE FOR LESS THAN MARKET VALUE

22 SEC. 45. Section 1904 of the Social Security Act is
 23 amended by adding the following sentence: “The Secretary
 24 shall not find that a State has failed to comply with the re-
 25 quirements of this title solely because it denies medical as-

- 1 That no payments will be made under this subpara-
- 2 graph, in the case of a hospital, for October 1980 or any
- 3 month thereafter.”.

Senator TALMADGE. Many constructive changes in the present bill, S. 1470, were included as a direct result of the testimony received on S. 3205. I believe we have made a good bill better.

Another proposal now receiving active consideration in the House of Representatives, H.R. 3, might well be regarded as the offspring of S. 3205. H.R. 3 is the "antifraud and antiabuse" bill which includes among its key provisions important sections taken from S. 3205. House passage of H.R. 3 is anticipated this month.

It is my intention to move promptly in committee as soon as the House version of my antifraud and antiabuse legislation is referred to us. The need for basic reform of medicare and medicaid is urgent. The two programs will cost Federal and State taxpayers more than \$47 billion in fiscal 1978—some \$9 billion more than in fiscal 1977 and \$15 billion more than the \$32 billion cost in fiscal 1976. The increasing costs of these programs continually outstrip the rate of rise in Federal revenue.

The choice is a simple one—either we make medicare and medicaid more efficient and economical or we reduce benefits. Indeed, many States are already cutting back on their medicaid programs. But, there is an overriding need to get a handle on medicare and medicaid costs apart from the Federal, State and local budget effects.

There is no question but that the way we pay for care under our programs serves to inflate health care costs for all Americans. That situation needs correction now. There is an absolute need for Federal and State government to effectively manage the existing health care programs. It would be difficult, if not foolhardy, to extend health insurance coverage to other segments of the population until we are satisfied that we can properly manage what we now have.

This hearing, of course, is not on the subject of the administration's hospital cost containment proposal. While that bill must ultimately come before this committee, it is currently being considered by the Senate Human Resources Committee, which has jurisdiction over a part of the bill, and the Ways and Means and Interstate and Foreign Commerce Committees in the House of Representatives. At such time as the House completes action on the administration bill, or when the Human Resources Committee reports out a bill, we will of course give prompt attention to the proposal in the Finance Committee.

With respect to the hospital reimbursement provisions contained in S. 1470, support has been expressed based upon it being an equitable means of rewarding efficient hospitals and penalizing only inefficient institutions. The thrust of section 2 of S. 1470 is that the reasonableness of a given hospital's costs is to be determined by comparing those costs with similar costs in similar hospitals.

But at the hearing last year on S. 3205 and in discussion elsewhere this year, three principal criticisms have been made of the hospital provision in both S. 3205 and the counterpart in the present bill, S. 1470. I think it is important that each of these points be addressed at the outset of this hearing.

The first argument is that section 2 of the bill applies only to the hospital care provided to medicare and medicaid patients—that it does not extend to the balance of hospital care. I indicated when introducing S. 1470 that, if a consensus developed to apply similar rewards and

penalties across the board, I would not be averse to extending the provision to cover all hospitals. That is still my view and the staff of the committee has been working at my direction on possible approaches which could be considered if the decision is made to extend section 2 across the board.

The second argument is that the bill covers only adjusted routine hospital costs and does not apply to other hospital costs. The reason for this limited initial approach is simple. We did not believe that we had the expertise to make reasonable comparisons of costs other than adjusted routine at the outset of the program, but the bill specifically provides that, just as soon as that expertise becomes available, the scope would be broadened to include other hospital cost centers. In response to this particular concern, I have had the staff working and consulting to see whether the methodology in section 2 could be applied to more than just routine costs at the outset.

The staff now advises me that they believe it might be feasible to extend section 2 in such a way as to apply to something like 75 or 80 percent of hospital costs when it becomes effective. Assuming that the staff suggestion is reasonably workable and reasonably equitable, and if it includes appropriate appeals procedures to avoid unfair treatment, I would certainly be agreeable to modifying S. 1470. The staff advised me that they will have an outline for possible expansion of hospital costs initially covered by S. 1470 by the time markup on the bill begins.

The third criticism of the Talmadge bill is that its penalties and incentives would not apply until fiscal 1981 and that without something in between, hospital costs will continue to soar. I think that a careful reading of S. 1470 reveals that it will have a positive impact on hospital costs well before fiscal 1981. While, in fact, the penalties would be applied and the incentive payments made in fiscal 1981, those amounts would be based upon fiscal 1979 performance by the hospitals; that is, in the year beginning October 1, 1978.

The way it works is this—following the close of fiscal 1979, the Secretary has 6 months to gather and compare hospital cost data. By April 1, based upon that data, he announces that, effective October 1, 1980, 6 months later, hospitals will be paid on the basis of their 1979 costs performance adjusted for the average of any inflation occurring between the end of fiscal year 1979 and the beginning of fiscal 1981.

The point here is that hospitals which are high cost or otherwise inefficient will have every incentive to moderate their operations in the year beginning October 1978, if not earlier, because that will determine whether they are penalized or rewarded in fiscal 1981. It is reasonable to assume that many hospitals will act in fiscal 1979 to moderate costs, where they can, in hope of gaining an incentive payment or avoiding penalty.

As a matter of fact, under the bill, the Secretary, in 1978, publishes advisory information showing hospitals where they would rank if the program had been in operation. The purpose of this is to give high-cost hospitals more time to adjust or moderate their operations.

I seriously doubt that in the relatively short time between now and October 1, 1978, that hospitals would indiscriminately allow their costs to go up. If they did so—and remembering that fiscal 1979 is the base year—those hospitals would run serious risk of having costs determined to be excessive or disallowed. I also think it important to stress

that the savings in the S. 1470 approach would derive from moderating the rise in hospital costs rather than the actual difference between the penalties and the incentive payments.

Some have engaged in a numbers game saying that my bill would only save such and such an amount. Unfortunately, their calculations are based only on simple subtraction—that is, adding up all the incentive payments and then subtracting that total from the reduction in payments to excessively high-cost hospitals. I cannot stress too much that the real savings will come from cost moderation and not penalties.

The reason is that high-cost hospitals will act to bring down their costs to levels which are fully reimbursed. Other hospitals will act to moderate their costs so as to gain incentive payments or to avoid moving into the range where a portion of their costs are not reimbursable. The effect of all of this will be to moderate the average costs of hospitals as they are recalculated each year.

This would occur as the high-cost institutions—those hospitals close to or above the penalty levels—moderated their costs thereby favorably affecting the average cost which is, after all, determined by calculating in both the higher and lower cost hospitals.

S. 3205 contained a section establishing a new agency, the Health Care Financing Administration. That agency was intended to consolidate medicare, medicaid, the Bureau of Quality Assurance, and some minor offices in order to cut redtape, eliminate overlapping and duplicative activities and personnel, and do away with the pancake layers of bureaucracy which repeatedly hampered effective and timely policy-making by the operating agencies.

I was more than pleased when Secretary Califano and President Carter announced that, under administrative authority, they were establishing the new Health Care Financing Administration. This was the first major reorganization undertaken. Unfortunately, the concept I had appears to have lost a great deal in translation.

The new Health Care Financing Administration, as proposed, appears in large part to represent nothing more than another massive bureaucratic boondoggle. A boondoggle which occurred because the dismantling of the Social and Rehabilitative Service—the welfare bureaucracy—happened simultaneously with the establishment of the Health Care Financing Administration.

The task force established to develop the structure and functions of the new Health Care Financing Administration consisted principally of people—not from medicare, medicaid or the Bureau of Quality Assurance—but rather from the defunct Social and Rehabilitation Service. In fact, the five-member so-called core staff developing the reorganization plan came directly out of the Social and Rehabilitation Service.

The people from the actual agencies consolidated—medicare, medicaid and the Bureau of Quality Assurance—those with primary understanding of the tasks to be accomplished by the new organization, were not included in this select “core” group. To no one’s great surprise, what evolved was a top-heavy superstructure designed to not only assure the survival of all existing grade levels and positions, but also to provide new opportunities for supergrades as well as provide the potential for a general escalation of grades at all levels.

Let me be quite specific. Based on information in HEW memoranda and from HEW staff directly involved in reorganization activities, the principal concern of the task force clearly appears to lie far more with the dismemberment of SRS and not the creation of an effective and efficient Health Care Financing Administration.

There was the task force concern over how to justify all the personnel in view of President Carter's desire to streamline the Government and make it more efficient. There was concern over how to broaden the administrative structure since there was no increase in statutory responsibilities. There was no discussion, however, of efficiencies—such as elimination of duplicative jobs—that could be gained by consolidation; this was just not addressed.

One of the first tasks of the reorganization task force was not to develop a structure that would reflect the benefits of true consolidation where one chief might serve in place of two; it was to justify supergrades. Under the approach taken, the mathematics of consolidation did not have one and one equalling two or less but equalling three or more. It gets worse.

Before the so-called consolidation, the Bureau of Health Insurance, the Medical Services Administration, the Bureau of Quality Assurance, the Office of Long-Term Care, and the Division of Health Insurance Studies has a total of exactly 13 supergrade employees. In fact, there was one vacancy within that total of 13.

Our latest information is that the new Health Care Financing Administration will now ask for 29 supergrades, nearly 2½ times the current number. This is apart from the confusing and unnecessary layer upon layer of staff offices that have been part of the problem in the past and which prompted me to seek a legislative remedy.

By last count there were 21 divisions and 18 offices being proposed as part of the Health Care Financing Administration superstructure and we have not started counting the offices and divisions and branches of the operating programs, many of which are being upgraded to cash in on the bureaucratic bonanza.

And there is more—the Medical Services Administration, the agency responsible for medicaid had a total of 387 central and regional personnel. But, 568 Social and Rehabilitation Service employees are coming in on top of medicaid's 387.

Time after time we have been told by responsible and very much concerned and outraged HEW employees at all levels that the basic mission has become one of protecting grades and positions. Our files show instance upon instance where this new agency is breeding duplication and overstaffing and not eliminating them as we in the Congress intended.

The proposed Health Care Financing Administration appears to be another good idea bogged down in the quagmire of bureaucratic self-interest. The President and the Secretary could use a little help from the Congress in dealing with these elements of the HEW bureaucracy. It may well be necessary for us to specifically legislate the organization and staffing of the new Health Care Facilities Administration. For that reason, S. 1470 includes the section statutorily establishing the new agency.

In fact, the simplest thing to do might be to just incorporate all the medicare and medicaid activities into the Bureau of Health Insurance and then rename that agency the Health Care Financing Administration. I believe we have a representative range of witnesses this week.

It is my hope that these hearings will provide the basis for timely congressional action on necessary changes in the way Government conducts medicare and medicaid. As I have stated repeatedly, none of the provisions in S. 1470 are locked in concrete. Hopefully, constructive changes and improvements will be a product of these hearings.

Senator Dole, do you have a statement that you wish to make?

Senator DOLE. Thank you, Mr. Chairman. I have a brief statement.

I am pleased to join with you and other members of the subcommittee, when they appear, to hear comments on S. 1470. I can only echo much of what you have said, Mr. Chairman, regarding the rapid rise in health care expenditures, particularly the Federal share of these expenditures. I, like you, Mr. Chairman, feel that the hearings held last year on your similar proposal provided us with many constructive suggestions. The result we have before us today is this bill.

As ranking Republican member of this subcommittee, I am particularly interested in seeing that meaningful improvements are made in the medicare and medicaid programs.

We are familiar with the figures which show that total health care spending comprised 4.5 percent of the GNP in 1950, while today it amounts to approximately 8.6 percent. Projected fiscal year 1978 spending for medicare and medicaid programs alone account for \$47.5 billion. But the significance stretches beyond those expenditures.

The average American citizen is also required to spend increasing out-of-pocket costs for health care either directly or indirectly through insurance premiums and taxes. We must recognize that the delivery system itself is not completely responsible for generating those inflationary pressures. Rising labor and supply costs, the need to constantly upgrade equipment and physical facilities, skyrocketing malpractice premiums, and compliance with proliferation of new regulations have all contributed.

In my view, the proposal we are discussing today addresses many of these problems realistically. As a Senator from the State of Kansas, many sections of which are less densely populated, I understand the importance of provisions that consider the differences in hospital needs because of their differing location, size, and patient mix.

Section 11 which provides incentives for physician practice in low-fee shortage areas is of special importance to States such as my own, where physicians are badly needed, but where recruitment is difficult.

Mr. Chairman, I join you in welcoming the witnesses who are with us today and those we will hear from in the next 3 days. I believe that there is a consensus among the members of the committee that no provision of this legislation is written in concrete. We look forward to hearing suggestions and possibilities for improvement.

I will be particularly interested in hearing Mr. Califano's remarks regarding the proposed organization of the new health care financing

administration. I share Senator Talmadge's concern that as proposed, the new administration would not only not reduce the bureaucracy but would add to what has already become the catastrophic illness of our multifaceted, poorly functioning governmental structure.

For example, it has come to my attention that in the Kansas City HEW regional office, the social rehabilitation service has 76 employees. Of these, only 14 have responsibility for medicaid. Under the new reorganization plans, 36 of the 76 employees are being sent to the health care financing administration. So above the 14 medicaid employees, 22 additional social rehabilitation service personnel are being superimposed. The balance—40—will go to the Office of Human Development and the Social Security Administration.

Mr. Chairman, I am convinced after hearing your remarks and after having heard of the instance I mentioned, that the issue of the present reorganization plans should be considered carefully by our subcommittee. It is quite clear that there are serious problems with the proposed reorganization of the health care financing administration.

I would respectfully suggest that the subcommittee request the Comptroller General to evaluate the entire situation and report back to us within 30 days. I think he should find out whether this new agency is developing more as a bureaucratic Frankenstein than as a means of doing a better job with fewer people.

The Comptroller General should be supplied with all of our committee files dealing with the development of HCFA. He should be asked to consult with the Civil Service Commission apart from reviewing the matter with any Health, Education, and Welfare people he thinks knowledgeable.

It would also be helpful if the Secretary would agree to hold off with further implementation of the HCFA until we have all had a chance to review the report of the Comptroller General.

Mr. Chairman, that concludes my remarks, but I would hope that there would be some immediate action taken in reference to the suggestion, certainly, of the Comptroller General. I am pleased to be working with you on this. We just successfully completed a farm bill. Maybe we can have some luck on the health legislation.

Senator TALMADGE. Without objection, that recommendation will be adopted.

[The following is the formal request of the subcommittee to the Comptroller General:]

U. S. SENATE, COMMITTEE ON FINANCE,
Washington, D.C., June 14, 1977.

HON. ELMER B. STAATS,
Comptroller General of the United States,
General Accounting Office, Washington, D.C.

DEAR MR. STAATS: On June 7, 1977, during hearings before this Subcommittee, the Subcommittee, on formal motion, agreed to request your Office to review the development and organization of the Health Care Financing Administration in the Department of Health, Education, and Welfare. Subsequently, members of our respective staffs have been in consultation on this request.

As you know, the concept of bringing the Medicare and Medicaid programs, health standards activities, and the Professional Standards Review Organization program under one organization was included in my bill S. 3205 introduced in the last session.

Because of my concern that this organization has been attributed to a concept closely identified with myself, on May 5, 1977, I wrote to Secretary Califano

expressing my dissatisfaction with respect to the new reorganization. Specifically, my concerns dealt with—(1) the apparent proliferation of new superagencies, (2) the fragmentation of authority and responsibility through the submergence of the principal operating bureaus (Medicare, Medicaid, and Health Standards and Quality), and (3) the proliferation and possible overlapping of staff activities reporting directly to the Administrator.

By letter dated June 2, 1977, the Secretary responded to my concerns. However, in the judgment of the Subcommittee, this response was not satisfactory. In fact, detailed information received by the Subcommittee on Health subsequent to my May 5 letter has served to reinforce the concerns expressed in that letter.

Therefore, I am requesting the General Accounting Office to make an immediate review of this new organization with emphasis on the following issues:

A. PROLIFERATION OF SUPERGRADES

1. How many supergrades were authorized in the operating agencies consolidated?

2. Immediately prior to the HEW reorganization, how many supergrade positions were authorized in the Social and Rehabilitation Service? Of these, how many were vacant? With the reorganization on March 8, 1977, the Service was disbanded and its functions were distributed to the new Health Care Financing Administration, the Office of Human Development, and the Social Security Administration. In these organizations (i.e., HFCA, OHD, and SSA) how many supergrade positions were designated and how many supergrade employees were assigned?

3. We understand that supergrade-level job classifications are subject to approval by the Civil Service Commission. What is the status of the approval process—both within CSC and OMB—for the supergrade positions being proposed for the Health Care Financing Administration;

4. What has been the result of prior reviews by the Civil Service Commission of the grade structure of the Social and Rehabilitation Service as it pertained to supergrades as well as Grades GS-14's and 15's;

5. Of the supergrades being proposed, how many would be assigned to a staff function as opposed to a line or operation function and does the General Accounting Office believe that the mix would be appropriate?

B. FRAGMENTATION OF AUTHORITY AND RESPONSIBILITY

1. Obtain the views of key officials of the operating bureaus as to their role in the new organization and as to whether they view operating effectiveness and policymaking enhanced or diminished.

In connection with any interviews, it would be appreciated, where requested by the individual concerned, that confidentiality as to his identity be observed.

2. Over the years a basic problem at HEW has been the timely promulgation of regulations pertaining to the health programs. If possible, please provide a flow chart showing how proposed regulations dealing with (a) reimbursement, and (b) Professional Standards Review, would be developed through the hierarchy of the new Health Care Financing Administration.

3. Historically, the heads of the operation bureaus for Medicare and Medicaid have been authorized to submit program related instructions to intermediaries, to carriers, and to the States. Will this authority remain or will it be diluted under the new organization? Specifically, what will be the authority of the Bureau operating heads with respect to developing and signing correspondence to members of Congress and the public, and what will be their authority and responsibility in issuing instructions to contractors and State agencies?

4. To what extent will staff offices (such as the Associate Administrator for Policy, Planning and Research) be involved in the flow of official communications between the Bureau heads and the Administrator or Deputy Administrator?

C. PROLIFERATION AND POSSIBLE OVERLAPPING OF STAFF ACTIVITIES

1. Identify any evidence of duplication or overlapping from the functional statements of the various offices and Bureaus, and divisions of the Health Care Financing Administration.

2. Does the General Accounting Office see any opportunities to combine or consolidate any of the offices or divisions of the new organization?

3. Is there *any* evidence that the structure was designed to accommodate grades and personnel rather than to serve to enhance functional efficiency in timely policymaking and operations?

4. Is there any evidence of duplication or overlapping of stated functions between the Bureaus' offices and divisions of the Health Care Financing Administration and the similar organizational elements of other organizations within HEW? For example, what functions of the Associate Administrator for Policy Planning and Research in the Health Care Financing Administration are duplicated or overlap among the functions of the Office of the Actuary in the Social Security Administration, and the National Center for Health Statistics and the National Center for Health Resources Research in the Public Health Service?

Our current bill, S. 1470, proposes reforms of the administrative and reimbursement procedures for Medicare and Medicaid, including a provision for the legislative establishment of a Health Care Financing Administration. Therefore, it is requested that you or your representatives be prepared to provide the results of their review no later than July 18, 1977, for the Subcommittee's consideration in connection with S. 1470. We realize that many of the issues pertaining to the HEW reorganization involve judgments; nevertheless, because of your staff's extensive experience in auditing the administration of the health programs involved, their views would be of obvious value to the Subcommittee. In this connection, we noted that, in his testimony of June 7, Secretary Califano also welcomed this study of the HEW reorganization which includes the establishment of the Health Care Financing Administration.

Quite simply, the basic questions are: Does this organizational structure enhance or impair effective and timely coordinated policymaking and operations? Are duplicative or parallel functions and jobs consolidated or eliminated at central and regional levels?

With every good wish, I am

Sincerely,

HERMAN E. TALMADGE,
Chairman, Subcommittee on Health.

Senator TALMADGE. Do you have a statement, Senator Danforth?

Senator DANFORTH. No, thank you, Mr. Chairman.

Senator TALMADGE. The subcommittee is indeed honored to have the distinguished Secretary of HEW this morning.

Mr. Secretary, you may proceed in any manner that you see fit.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Secretary CALIFANO. Thank you, Mr. Chairman.

It is always a pleasure to see you and Senator Dole and Senator Danforth. I would like, Mr. Chairman, to submit my entire statement for the record. I will read some excerpts of it.

I appreciate the opportunity to appear before this distinguished Subcommittee on Health to discuss S. 1470, the proposed Medicare-Medicaid Administrative and Reimbursement Reform Act.

I would like to make some general comments on S. 1470. Then perhaps I will direct some comments to the remarks of the chairman and Senator Dole.

Last session, the Finance Committee, through this subcommittee, again provided leadership in identifying serious problems and devising needed reforms in the Nation's health care system.

In less than 6 months in office, we in the new administration have moved to support or to implement the most urgent of those reforms.

First, in the 94th Congress, you introduced legislation to remedy serious problems created by fraud and abuse in the medicare and medicaid programs. You recognized that fiscal integrity and sound

management practices must characterize these programs if they are to enjoy the trust and confidence of the American people.

This year, the fraud and abuse legislation has been introduced separately in both houses of Congress, with strong endorsements from the President and from me. That legislation should soon pass the House and we look forward to the opportunity to urge its passage in the Senate.

Second, your health care reform legislation in the 94th Congress proposed establishment of an Inspector General for Health within the Department of Health, Education, and Welfare. That proposal—expanded so that the jurisdiction of the Inspector General includes all programs of HEW—became law last year, and we have acted quickly to implement it.

The new Inspector General, Tom Morris, and the new Deputy Inspector General, Charles Ruff, are men of superb qualifications who have been moving swiftly to organize their office and to begin the vital work of reducing fraud and abuse in HEW's programs, especially in the Department's health programs.

Third, you have proposed, both last session and in the present Medicare-Medicaid Administrative and Reimbursement Reform Act, that the health care financing functions of the Department be consolidated into a single administrative structure.

President Carter endorsed this concept early in the presidential campaign. As you know, less than 60 days after assuming office, I effected this much needed reorganization through administrative action. As I noted at the time of the reorganization, we are deeply indebted to the work of this subcommittee and to the illuminating hearings that you held last year on the problems of health care financing.

We have high expectations for this element of the Department's reorganization. The Health Care Financing Administration should significantly improve the effectiveness, efficiency and responsiveness of medicare and medicaid by coordinating the policies and practices of the two programs and by eliminating, or reducing, unnecessary and costly duplication in their operations.

By joining these programs under one administrative structure, we should also realize important economies through reduction of fraud, abuse and leakage. I have with me Mr. Robert Derzon, one of this Nation's outstanding hospital administrators, with tremendous experience in New York City and in San Francisco, who was sworn in as the head of the Health Care Financing Agency last week. I am delighted that Mr. Derzon agreed to disrupt his family and personal life. He has been in San Francisco a relatively short time.

We searched long and hard for someone for this task. He is unquestionably the finest person in this country to do it. He did a spectacular job in New York City and in New York State, and he will, in my judgment, vindicate all the glowing reports that we received when we checked him out around the country, as he takes over this agency and puts it into motion.

I also have with me Ms. Karen Davis, Deputy Assistant Secretary of HEW for Health in the office of the Assistant Secretary for Planning and Evaluation.

Senator TALMADGE. I am delighted to have both of them before the committee.

Secretary CALIFANO. We believe that the structure presently contemplated is an appropriate first step in the development of a sound HCFA organization, and that it will be fully consistent with the intent of your health care financing proposal. At this time, it is essential that we continue to have flexibility to adapt organizational structure to the programmatic needs that emerge from practical, day-to-day experience. We do not, therefore, believe that legislation establishing HCFA is necessary to achieve the desirable goals of consolidating medicare and medicaid administration.

Mr. Chairman, there is another problem identified in the proposed legislation that the administration views as being of the greatest urgency—the methods by which hospitals are reimbursed for services provided to medicare and medicaid beneficiaries and the skyrocketing increases in hospital costs that are caused, in substantial part, by present reimbursement methods.

I would like to devote much of my remaining testimony to this fundamental issue because it is a matter of signal importance and because the President has proposed legislation, the Hospital Cost Containment Act of 1977, which also addresses the problem.

As you noted when introducing S. 1470, the administration bill is a stopgap, transitional measure that complements the long-term structural reform contained in the Medicare-Medicaid Administrative and Reimbursement Act.

As this subcommittee knows well, the medicare and medicaid programs presently reimburse hospitals for reasonable costs incurred in providing services to program beneficiaries. This retrospective payment method has proven to be highly inflationary, because reimbursement simply covers rising hospital costs, however unnecessary or wasteful those costs may be. By reimbursing hospitals for most incurred costs, this method provides virtually no incentives for efficiency.

As this subcommittee also knows well, this method of reimbursement—which also applies in other health programs—has contributed to rampaging inflation in the hospital industry, which constitutes 40 percent of health care costs. If we take no action now, total health expenditures will double between 1975 and 1980; hospital costs paid by medicare and medicaid will double even sooner; total hospital spending could reach \$220 billion by 1986; and the share of the Federal budget that goes to hospitals will rise steeply above the present 9 cents of every dollar.

Mr. Chairman and members, we must either take some fairly stringent action or find the way to pick up the tab through increased taxes on the American taxpayers.

Section 2 of S. 1470 would establish a prospective reimbursement system for hospitals participating in medicare and medicaid. In essence, this is accomplished by classifying hospitals according to bed size and type and by establishing prospective limits on per diem routine operating costs for hospitals in that group.

We believe that the concepts underlying section 2 of the proposed legislation are sound and another testament to this subcommittee's foresight. Reimbursement of hospitals must be shifted from retrospective to prospective; prospective limits on hospital costs should be based on different types of hospitals; and these limits should encourage efficiency and penalize inefficiency. These concepts, as the President has stated, must clearly be part of meaningful reform.

But, although we support the concepts underlying section 2 hospital reimbursement requirements, let me share with you some of the difficulties we have with that provision as presently drafted.

First, the provision applies only to medicare and medicaid payments, which constitute about one-third of hospital spending nationwide. Holding down medicare and medicaid payments alone could simply encourage hospitals to refuse these patients, to provide such patients with second-class care, or to transfer their costs to other payors.

Mr. Chairman, I was delighted to notice in your opening statement that you would consider extending coverage to all hospitals. In Colorado, for example, where the State imposed limits solely on medicaid, other hospital costs in that State rose by 40 percent. So if you do not cover it all, there will be a balloon—it is like putting your hand on one part of a pillow and watching the rest of it blow out.

Second, we do not yet have adequate data or methodologies to classify hospitals according to relevant cost-based characteristics—and such a classification is, of course, necessary for a sound, long-run prospective reimbursement system.

Although section 2 significantly improves on the present method of classifying hospitals—which is required under section 223 of the Social Security Amendments of 1972—by using local wage base data as an important variable, we simply do not have such data at present for most localities in the United States.

I do not know how long it will take to get such data. I know that most of the data changes we made in the mid-60's were requested from the Bureau of Labor Statistics and the Commerce Department. They were not in effect for several years.

A sound classification should take into account not just bed size and types of hospitals, as proposed in the bill, but also the types of patients in hospitals of equivalent size and type. Obviously, a 200-bed, short-term general hospital with a large fraction of obstetrical patients will have different costs than a 200-bed short-term general hospital with a large fraction of cardiac patients. Unfortunately, we presently lack the methodology to classify hospitals by types of patient—that is, by the type of diagnostic patient case mix.

Similarly, the bill proposes that "teaching" hospitals constitute one of three types of hospitals—along with short-term general and speciality hospitals. Again, we presently lack an agreed-upon methodology for determining whether, and to what extent, an institution is a "teaching hospital."

We do not believe that these are insurmountable barriers to a sound prospective reimbursement classification system, and we look forward to working with you to develop such a system. But these difficulties are real obstacles in the short term.

Third, and related to the point immediately above, section 2 covers only about 35–40 percent of present hospital costs and does not include such critical expenditures as capital costs, education and training costs, malpractice insurance expenses, energy costs, and so-called ancillary costs—for example, the costs for expensive operating rooms or high-priced X-ray machines. Hospitals may be able to circumvent section 2's restraint on a limited proportion of their costs by shifting costs to other, uncovered areas—for example, ancillary costs—or by increasing the lengths of patient stays.

I was delighted, again, to notice in your opening statement a flexibility to extend the coverage of this legislation should we, or others, be able to convince the subcommittee that that is an important thing to do.

Senator TALMADGE. We would be delighted to have your recommendations in that regard, Mr. Secretary.

Secretary CALIFANO. Thank you, sir.

Fourth, we seriously question whether a specific classification system should be actually written into a statute. Even when we are able to devise an adequate classification system for prospective hospital reimbursement, we will be continually refining our data and methodologies. Flexibility should be built into the statute to allow for improvements without additional legislation.

Fifth, section 2 does not place a limit on actual increase in hospital costs over time but instead bases its limits on the average costs for types of hospitals. Thus, if all hospitals increase their costs substantially from one year to the next, this provision would permit reimbursement to rise accordingly.

The skyrocketing, 15-percent-a-year increase in hospital costs would continue interminably.

Finally, section 2, while pointing the way toward sensible changes in reimbursement techniques, will not, in our judgment, effectively control costs in the immediate future. Indeed, our preliminary, relatively conservative estimates indicate that section 2 could cost up to \$50 million more in fiscal year 1978—even if it could be fully implemented—than the present cost-limiting provisions already in law.

Not only could section 2 add as much as \$50 million to President Carter's fiscal year 1978 budget, but its costs appear to increase with time—to approximately \$55 million in fiscal year 1979, \$64 million in fiscal year 1980, and \$75 million in fiscal year 1981.

If modifications could be devised to meet the difficulties discussed above, however, then we would expect substantial long-term savings from section 2.

I might note, Mr. Chairman, in view of your opening statement, the professional actuaries who did the analysis included a factor for the effect of incentives. I will submit for the record all of their detailed work, because I think it would be helpful for your experts to look at what our professional people have done.

Senator TALMADGE. We would be pleased if you would submit that data, Mr. Secretary.

Secretary CALIFANO. Thank you, Mr. Chairman.

[The following was subsequently supplied for the record:]

JUNE 3, 1977.

Note to the files.

Subject: Summary of selected Talmadge bill (S. 1470) provisions and cost estimates for HI.

Following is a brief description of the provisions of S. 1470 which are expected to have a significant impact on HI, the expected financial impact of such provisions, and the principal assumptions underlying these estimates.

SECTION 2—REIMBURSEMENT FOR ROUTINE OPERATING COSTS OF INPATIENT HOSPITAL SERVICES

A uniform system of accounting and cost reporting would be established, and hospitals would be classified by bed size, type of care, etc. Routine operating costs (i.e., costs other than capital and related costs, education and training costs, intern-resident-physician costs, heating and cooling energy costs, malpractice insurance costs, and ancillary service costs) would be reimbursed on the following basis:

(a) An "adjusted per diem payment rate for routine operating costs" would be established for each classification cell, based on average routine operating costs for the cell and adjusted for price increase.

(b) A hospital which has actual routine operating costs greater than or equal to this rate would receive its actual costs, subject to a maximum of 120 percent of the greater of (1) the rate for its cell and (2) the rate for the cell in the nearest bed-size category.

(c) A hospital which has actual routine operating costs less than the "adjusted payment rate" would receive its actual costs plus the lesser of (1) 50 percent of difference between actual costs and the payment rate and (2) 5 percent of the payment rate.

Certain other adjustments and exclusions are identified in the bill.

This section of the bill would be fully effective for hospital fiscal years beginning with fiscal year 1981. The following estimates illustrate the impact of this section without regard to the implementation schedule, based on a fully implemented, full-year, incurred basis:

COST IMPACT

[In millions]

	Implementa- tion of S. 1470	Elimination of sec. 223	Net impac
Fiscal years:			
1978.....	-\$90	+\$135	+\$45
1979.....	-100	+150	+50
1980.....	-120	+175	+55
1981.....	-140	+200	+60
1982.....	-160	+230	+70

The above estimates, both for Section 223 and Section 2 of S. 1470, were based on distributions of Medicare hospital routine cost per day amounts by bed size, metropolitan-nonmetropolitan, and other classifications. Specific recognition was given to (1) the types of costs excluded from coverage and the various exception or adjustment provisions under S. 1470 and (2) the exception categories under Section 223. The net result is a reduction in average hospital reimbursement levels of 0.5 percent under S. 1470 (a reduction of 1.2 percent due to the upper limit, partially offset by a cost of 0.7 percent due to the incentive provision) versus 0.7 percent under Section 223. Although the 120 percent limit under Section 2 is more stringent than the present limitation under Section 223, the "incentive" provision offsets a part of this higher level of savings; this results in lower total savings than under Section 223.

SECTION 3—PAYMENTS TO PROMOTE CLOSINGS OR CONVERSION OF UNDERUTILIZED FACILITIES

Capital and increased operating costs associated with the approved closing or conversion of underutilized bed capacity or services would be recognized as reasonable costs for reimbursement purposes.

This section of the bill would be effective upon enactment, with applications for approval to be accepted beginning with January 1, 1978, but with a maximum of 50 approvals to be granted prior to January 1, 1981. The following estimates illustrate the full impact of this section, without regard to the 50-hospital limit:

Fiscal year:	Cost impact (millions)
1978 -----	\$-85
1979 -----	-100
1980 -----	-115
1981 -----	-135
1982 -----	-155

These estimates were based on a distribution from a 500-hospital sample of the number of hospitals, the number of hospital beds, and the amount of hospital expenses by occupancy rate. A target minimum occupancy rate, for purposes of this section, was assumed to be 70 to 75 percent; a reduction in the supply of beds nationally of about 5 percent would result if all hospitals were raised to this level by reducing the number of beds maintained. Partial or full closing was assumed to be practicable in settings accounting for $\frac{1}{3}$ to $\frac{1}{2}$ of these beds, on a dollar-weighted basis (i.e., reflecting the fact that the bulk of the hospitals with the lowest occupancy rates tend to be smaller hospitals with relatively low levels of cost, where closing tends to be less feasible). The marginal savings between (1) maintaining an empty bed and (2) ceasing to maintain such a bed but recognizing certain residual costs was assumed to average 20-30 percent, based on the hospital expense categories that could be reduced or eliminated. The net result is a potential level of savings of about 0.5 percent, under full implementation and full participation by the hospital sector.

SECTION 46—RATE OF RETURN ON EQUITY FOR PROPRIETARY HOSPITALS

The rate of return on equity recognized by the program would be increased from $1\frac{1}{2}$ times to 2 times the current interest rate on trust fund assets.

The section of the bill would be effective upon enactment, applicable to hospital fiscal years beginning after the month of enactment. The following estimates illustrate the full impact of this section:

Fiscal year:	Cost impact (millions)
1978 -----	\$30
1979 -----	33
1980 -----	36
1981 -----	40
1982 -----	44

These estimates were derived from data collected from a sample of Medicare cost reports for proprietary hospitals and from data published by the American Hospital Association on investor-owned short-term hospitals.

RONALD HARRIS.

TALMADGE BILL (SUMMARY OF ASSUMPTIONS USED FOR PART B ESTIMATES)

SECTION 10 (ADMINISTRATIVE COST SAVINGS ALLOWANCE)

Based on a National Center for Health Statistics survey and SMI program experience, it is projected that there will be 7 physician visits per SMI enrollee during fiscal year 1978. 25½ million SMI enrollees are projected for fiscal year 1978. Approximately 55 percent of SMI claims are submitted on an assignment basis. Therefore if \$1 is to be paid for each visit paid under assignment, the cost would be \$30 million for the three months that the provision would be effective in fiscal year 1978 and \$115 million during the full year, fiscal year 1979.

SECTION 11 (NEW PHYSICIANS IN SCARCITY AREAS)

Allowing new physicians in scarcity areas to establish their customary charge levels at the 75th percentile rather than the 50th percentile would add about 20 percent to present law reimbursement levels to those new physicians. This estimate is based on data from a survey of customary charges in Arkansas. From "The Supply of Health Manpower," it was estimated that 12 percent of new physicians (1700 in fiscal year 1978) would be working in scarcity areas. The new

physicians will be receiving an estimated \$13,000 per year in reimbursement from Medicare in fiscal year 1978. Therefore, the incurred cost of this program for fiscal year 1978 is \$5 million.

Section 11 (Statewide prevailing charge limit to locally prevailing charges). By denying the automatic, yearly adjustment to any prevailing charge level which is more than $1\frac{1}{3}$ times the statewide prevailing, a savings of approximately 1.6 percent of current physician expenditures would be achieved.

This estimate is based on an analysis of the 1977 prevailing charge levels and the 50th percentile levels in a sample of high frequency procedures for five states. Based on estimated current law physician expenditures of \$158 million in fiscal year 1978 the provision would save \$80 million.

SECTION 12 (REIMBURSEMENT FOR PATIENT R. & D.)

The change in the reimbursement procedure for inpatient radiology and pathology will affect only those physicians billing Medicare directly. Non-participating physicians will be reimbursed at 80 percent rather than 100 percent. An estimated \$200 million is projected for fiscal year 1978 for a total R. & P. expenditures paid directly. Assuming a 50 percent assignment rate for hospital based physicians there will be a savings of \$5 million in 3 months of fiscal year 1978 that the provision would be effective, and \$25 million in the full fiscal year 1979.

Summary of provisions and cost estimates for SMI

1. Administrative cost-savings allowance (section 10)—\$1 per eligible patient would be payable to a participating physician, which would cover all services billed for a patient included in a multiple billing listing. Effective July 1, 1977.

Fiscal year:	Cost (millions)
1978 -----	\$110
1979 -----	130
1980 -----	150
1981 -----	165
1982 -----	180

2. New physicians in scarcity areas (section 11)—New physicians in localities with low fee levels would be permitted to establish their customary charges at the 75th percentile rather than the 50th. Effective upon enactment.

Fiscal year:	Cost (millions)
1978 -----	\$5
1979 -----	5
1980 -----	5
1981 -----	5
1982 -----	5

3. Statewide prevailing limit to locality prevailing fees (section 11)—The statewide prevailing fee would be the 50th percentile for all customary charges in the state. If any prevailing charge in a locality is more than $\frac{1}{3}$ higher than the statewide prevailing, the locality prevailing would not be automatically increased each year. Effective upon enactment.

Fiscal year:	Savings (millions)
1978 -----	\$80
1979 -----	95
1980 -----	110
1981 -----	120
1982 -----	130

4. Reimbursement limit for inpatient R. & P. (section 12)—Reimbursement for inpatient radiology and pathology will be 100 percent only for participating physicians (i.e., those agreeing to accept assignment). Nonparticipating physicians will be reimbursed at 80 percent. Effective July 1, 1978.

Fiscal year:	Savings (millions)
1978 -----	\$20
1979 -----	25
1980 -----	30
1981 -----	30
1982 -----	35

5. Liberalized coverage of ambulance services (section 41)—Currently, ambulance service to a hospital outside a patient's locality is covered if the hospital is the nearest institution with appropriate equipment, personnel, and with the capability to provide necessary services. However, ambulance service to a more distant hospital solely for the services of a physician in a specific speciality does not make the hospital the nearest with appropriate facilities.

The proposal includes ambulance service to a hospital for the services of qualified medical personnel. Effective first calendar month beginning after date of enactment.

Cost—no more than \$2 million.

Secretary CALIFANO. For these reasons, Mr. Chairman, I share your views that the President's proposed Hospital Cost Containment Act of 1977 is complementary to S. 1470. The administration's cost containment proposal is a transitional program, designed to restrain the intolerable current rate of increase in hospital costs and to gain the time necessary to work out some of the difficulties that we see in the present version of section 2's hospital reimbursement reforms.

As you know, the President's bill limits increases in total hospital inpatient revenues to an annual rate of about 9 percent, beginning in October 1977. The program would cover the inpatient revenues of about 6,000 acute care and speciality hospitals, but exclude long-term, chronic care and new hospitals.

The basic limit would be set by a formula reflecting general price trends in the economy with an increment for increases in services. Each cost-based third party payor would apply the limits in interim and final payments, and would monitor hospitals for compliance with respect to its own subscribers.

Under present estimates, the savings resulting from implementation of the Hospital Cost Containment Act would be approximately \$1.9 billion in fiscal year 1978—including \$657 million in medicare and Federal medicaid and \$879 million in private funds. By fiscal year 1980, net savings would nearly triple to over \$5.5 billion, including \$2 billion in medicare and Federal medicaid and \$2.6 billion in private funds.

Thus, Mr. Chairman, as you stated on May 5, 1977, when introducing S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act "represents a long-term basic structural answer to the problem of rising hospital costs, whereas the administration is calling for a short-term interim cap on revenues to be in place only until a long-term solution can be established."

We recognize that our proposal is only a short-range measure, but it is no less necessary for being short-term and can serve the critical function of simply, quickly and effectively curbing the intolerable rise in hospital costs.

While I will not attempt to describe the administration's cost containment proposal in any great detail at this time, Mr. Chairman, I would like to take this opportunity to respond to several specific questions and concerns you expressed about the administration proposal in your statement introducing S. 1470.

You expressed concern that the administration proposal might establish a floor rather than a ceiling. Initially, when we were devising the proposal, I was worried about that, but I do not believe that hospitals will increase their revenues to the 9-percent allowable limit under our program. Experience with the economic stabilization program

indicates that a substantial fraction of hospitals kept costs and revenues within the limits imposed and did not automatically increase them to the maximum extent allowable.

Similarly, approximately one-fifth of all hospitals now voluntarily keep their cost increases below 9 percent annually even though they are not required by law to do so. Moreover under our plan, we have included provisions which would reward those hospitals coming in below the limit in any given year.

Mr. Chairman, you also indicated some concern that our exceptions are excessively generous.

We believe that we have restricted exceptions to only those conditions genuinely meriting some flexibility. There are only two basic grounds for exceptions—major changes in patient loads—more than a 15-percent increase in admissions—and major changes in new capital facilities or equipment.

In both cases local health systems agencies would have to approve exceptions. The hospital would also have to demonstrate that it had current assets less than approximately twice its current liabilities, and therefore was in need of additional revenue to make those major changes.

We also permit an optional adjustment for increases in wages of nonsupervisory employees. Wages have not been the driving force in hospital costs increases. Historic trends in hourly increases have been 7.2 percent for hospital nonsupervisory workers for the past 6 years. Even assuming that these wages should increase at a rate of 9.5 percent, the allowable revenue limit would be increased by less than a percentage point. This provision is important to protect low-wage hospital workers from any adverse impact of cost constraints and to recognize that their average wages today still are 15 percent below the wage for the average wage for nonagricultural workers in our economy.

You also expressed some reservations about our program's differential impact on efficient and inefficient hospitals.

We do not believe our program penalizes efficient hospitals. Efficient low-cost hospitals should not need increases greater than 9 percent. It is true, however, that our program does not eliminate all of the waste and inefficiency in the system. As I indicated earlier, one of the major technical deterrents to doing so is the lack of an adequate classification system for distinguishing efficient and inefficient hospitals. But our plan would penalize those inefficient hospitals whose costs are currently rising at a greater rate than 9 percent and put us in much better position to ferret out remaining inefficiency in a long-term solution along the lines you have proposed.

Furthermore, the administration proposal does build in a number of rewards for hospitals which choose to become more efficient.

Hospitals that close unnecessary facilities or eliminate duplicative equipment would have revenues for these services retained in the base—if the HSA approved discontinuance of these services. Thus, the hospital would be permitted a greater than 9-percent increase on remaining services.

Hospitals that work with their medical staffs to eliminate unnecessary tests, admissions, or days of stay would be permitted higher allowable revenue per unit of service—since our limit is on total revenue increases.

Mr. Chairman, you also indicated some concern about starting with a transitional cost containment program and then moving to a longer term system. As noted, we feel strongly that the problem of rising costs is of such disastrous proportions that we simply cannot wait for a perfect solution before acting. It is important, however, to provide for an orderly evolution. We have designed our transitional program so that it will be compatible with a number of more fundamental structural reforms of reimbursement methods, including the types of incentives for improved efficiency contained in your bill.

Finally, I would like to respond to one other query about the administration's program—namely, that any slowing of the rate of increase in hospital costs can only be achieved by lowering the quality of patient care.

That is absolute nonsense.

Mr. Chairman, your subcommittee has contributed significantly to our understanding that more is not always better in the health care system. Unnecessary medication, hospitalization, testing, and surgery can be positively harmful to health and can constitute poor health care policy. Our program provides a strong economic incentive for hospitals to work with professional standards review organizations to curtail this unnecessary utilization. Unlike the current cost reimbursement system, our program would reward the hospital which chooses to reduce the length of patient stay or reduce unnecessary admissions.

Mr. Chairman, one of the most important points related to the care, to the impact of our program on hospital care, is the fact that some hospitals in this country have become so obese that they are literally endangering the lives of the patients that they serve.

Both title I and title II of our plan would provide strong incentives for hospitals to reduce unnecessary specialized facilities. For example, studies have shown that to maintain minimum standards of quality, a cardiac center should perform four to six cardiac operations weekly. Over 80 percent of all hospitals performing cardiac surgical procedures do not meet this requirement. In fact, an independent study of a Massachusetts hospital, where 49 percent of open-heart surgery patients died during the period 1968–1975—an unusually high death rate—concluded that an inadequate number of open-heart operations at the hospital, and the resultant inexperience of the cardiovascular team, contributed to the poor results.

The administration's proposal can help eliminate underutilized cardiac care facilities, promote regionalization, and thus improve patient care.

Another area where substantial cost savings would be achieved with an actual improvement in quality of patient care in inhalation therapy. Mr. Chairman, your staff has alerted the Nation to alarming improper professional practices in this area. One study indicates that approximately \$500 million could be saved by eliminating those inhalation therapy procedures which are of dubious benefit.

In sum, with the help of this subcommittee, we have identified over \$5 billion in savings that can be achieved without harming patient care. A "fat list" of those wasteful or unnecessary items which could be trimmed back without affecting quality of care is appended to my statement.

For these, and for other reasons that I will hopefully detail before this subcommittee when it considers the Hospital Cost Containment Act of 1977, we believe that the administration's proposal is a necessary precursor to the major, structural hospital reimbursement reforms set forth in S. 1470.

Mr. Chairman, I will submit the rest of my statement for the record. I can either comment on some of the points that you made in your opening statement if you would like me to, or refer to one or two other items in your legislation that we think we should deal with directly, and also comments on Senator Dole's statement.

Senator TALMADGE. That would be fine.

Secretary CALFANO. As far as the Health Care Financing Agency is concerned, I wrote you a letter on June 2, which I am not sure you have yet received. I would like simply to make a couple of points from that letter.

One, the number of supergrades moving throughout the Department to the Health Care Financing Agency, those available to move into that Agency, is 28. We intend to use only 22 of those supergrades, and possibly an additional 5 in the regions.

If we do not need the five supergrades in the region, there will actually be a reduction.

The programs that HCFA will deal with involve \$40 billion in Federal Funds and \$10 billion in State funds—\$10 million beneficiaries, sensitive beneficiaries—the old and the poor—and 4,200 employees. I think that is a remarkably small number of supergrades to deal with an organization of that size.

As you well know, there are many organizations in this Government with a much larger number of supergrades. One example, in an area with which you are familiar, is the Foreign Agricultural Service, which has 20 supergrades, 751 employees and a \$43 million budget. It has, in effect, one supergrade for every \$2 million. We have less than one for every \$2 billion.

I think we need talent at the top of this Government. I have spent a large part of my time since I became Secretary trying to recruit that talent, and we need the grades to get that talent.

Also, as you know, the supergrades have to be justified independently with the Civil Service Commission and they will be submitted there.

I think we are doing as well as we can in that arena. I think it is a very modest request. I was surprised when ultimately we were able to hold to that number of supergrades, compared to the rest of the Government. I would be happy to compare that agency with any number of agencies in the Government.

Secondly, as far as the comment of Senator Dole regarding having the Comptroller General look at HCFA is concerned, I would be happy to have the Comptroller General do anything in HEW. I am trying to build the Inspector General's Office into our own Comptroller General, if you will. You will remember that from my confirmation testimony, and I am moving in that direction.

The organization of HCFA has moved along. I do not think there is any reason to stop the reorganization, pending that examination. It would have a very serious and deleterious effect on the beneficiar-

ies of these programs and our ability to meet the cost savings goals that we are setting.

Further, with the creation of HCFA and the other elements of the reorganization, I am trying to save about \$1.8 billion between now and 1981, then \$2 billion a year beginning in 1981, as a result of our reorganization, and I am pressed very hard to keep it on track and get in place the kinds of things that we need in place to meet these savings goals.

I would be delighted to have Mr. Staats and his people. One of the first things I did after I became Secretary of HEW was to ask the Comptroller General to come over with his top people to examine HEW, and I spent hours with him and found out all of the problems that they felt were there, all the changes they thought could be made. They are an extraordinarily able group of people. They were very helpful to me then; perhaps they can be very helpful again in this and other areas.

Senator DOLE. Thirty days more would not disrupt your program.

Secretary CALIFANO. No, I think we will have to go forward with the program. The thing is just on track, like a PERC system, the Navy system, where you set up points moving to something very large and complex. We are moving.

There are 15,700 people who are being changed as a result of this reorganization. It is a very complex organization. It will be completed within the next 10 days, 10 or 15 days. I think that it would be very wrong to delay that, but I would be delighted to welcome the Comptroller General—there is nothing that will, in any way, inhibit the Comptroller General's study or inhibit us in acting on any of his recommendations that are helpful.

Indeed, I think you will find that many of the suggestions that the Comptroller General and his people made to me in the meetings I had with them shortly after I became Secretary are indeed being incorporated in the reorganization of HCFA and the reorganization of other elements of the departments of HEW.

I share the subcommittee's concern. I share the concern of every committee in the Congress that looks at HEW that this Department needs to be better managed. I have devoted a substantial amount of time to relatively obscure management questions. For example, I discovered that there was no procurement system in HEW. We had a system in which we gave out \$7 billion a year in grants and contracts and had no procurement, no true procurement system, nothing comparable to NASA, for example. We had no certified contracting officers.

I put into place 3 weeks ago, after weeks of work, the first procurement system for training those officers, a system for establishing a cadre of trained people, a system, I hope, that will increase competitive bidding on our contracts and grants and displace some of the sole-source procurement.

The Department has several management problems. I am trying to address them.

The investigations undertaken by the committees of the Congress, including this committee and the Senate Human Resources Committee over the past several years, have provided ample suggestions and identification of many of these problems. I am trying to move as fast as I can on them.

I want this Department to be a model of efficiency in this Government. I intend to exert every energy I have in that direction.

Mr. Chairman, I will make two other comments, and I will then insert the rest of my statement in the record. These are larger matters of concern. One is a provision in the bill not directed at the reimbursement area, the provision for the secrecy of the payments made to doctors which would prohibit the Secretary of HEW from making available to the public and the press under the Freedom of Information Act or otherwise, the amounts of money paid to individual doctors by medicare. We strenuously object to that provision. We believe that sunshine is the greatest disinfectant for health care.

Senator TALMADGE. Would you yield at that point?

Secretary CALIFANO. Yes.

Senator TALMADGE. Would you guarantee the accuracy of the report? We inserted that provision in the bill because there has been inaccurate information.

Secretary CALIFANO. We have taken steps. I deeply regret the list that went out. It was not in many respects an accurate list. I expressed that regret directly to Dr. Samson of the AMA. We have taken steps to improve that.

At this time, in addition to an examination of our whole computer system, and of the computer systems of our payors, we are setting in motion a system of sampling payments made to individual doctors throughout the year, and before we release a list in the future we will be checking with the people who are being paid.

Senator TALMADGE. If you can guarantee the accuracy, I would have no objection to deleting that provision in the bill.

Secretary CALIFANO. Thank you, Mr. Chairman. It is important that the American people know who is getting their tax money.

The other point, Mr. Chairman, relates to the provision in the bill that would permit profitmaking hospitals to increase their profits.

Presently, profitmaking hospitals under legislation are permitted a profit rate of 1.5 times the long term Treasury bill rate. The long term rate on Treasury bills is now 7 percent. They are permitted a profit rate of 10.5 percent. Your legislation would permit them to increase their profit rate by 33 percent to two times the long term rate, permitting them profits of 14 percent.

We believe, as I pointed out in the fat list, that hospitals in this country make ample profit. All hospitals in this country made \$438 million in profits in 1970. In 1976, their profits were over \$1 billion.

We think by letting hospitals get even more profits, we would contribute to inflation. We really would be adding, as I said in another connection, even more sweets and deserts, pies, candy, and cream puffs, to the very obese hospital system that we have now in our Nation.

Mr. Chairman, I appreciate the opportunity to express these views. Let me underline one thing: the concept of prospective reimbursement is a critical concept for the future. You have identified that early. Many of the things that I have tried to do, both administratively and in terms of legislation that has been recommended, have come out of the work that you have done over the last several years.

I think that you, Mr. Chairman, and Senator Kennedy and your subcommittees, have made significant contributions to whatever we have been able to get done in these first few months and what we are trying to do in the future.

I think that I and the American citizens and those interested in the health care system should be deeply grateful to both of you and both of your subcommittees.

Senator TALMADGE. Thank you very much, Mr. Secretary, for a very fine statement.

On the profit of hospitals, I believe you have overstated the situation a little. We have limited a 15-percent return on equity, which we thought was rather reasonable. We think we have the same constraints on for profit hospitals that we did earlier.

If you have any recommendations to perfect it, we will be delighted to have them.

I would also like to say at this point that I invited Senator Kennedy, chairman of the Subcommittee on Health of the Committee on Human Resources, to sit with us this morning. Unfortunately, he was unable to be present.

Mr. Secretary, S. 1470 contains a subsection establishing a procedure for developing and utilizing relative value schedules in determining the reasonableness of physicians fees. I believe proper safeguards have been included to adequately protect the public interest.

Do you have any views on this section of the bill?

Secretary CALIFANO. Mr. Chairman, we think that eventually the health care system and the Government will have to deal with physician's fees. Early this year, President Carter and I considered a recommendation that had been made to us with relation to physician's fees. We rejected it, because we felt that we did not know enough about it.

I guess my answer to your question is that we believe something has to be done about physician's fees. I am not 100 percent certain that the precise way that it is done in this bill is the best way to do it, and I think we can provide a more sophisticated response to that question if we just have a little more time.

Senator TALMADGE. Would you send us a recommendation specifically on that particular proposition?

Secretary CALIFANO. I will, Mr. Chairman.

Senator TALMADGE. And on value schedules?

Secretary CALIFANO. Yes, sir.

Senator TALMADGE. On page 12 of your statement, you say that one-fifth of all hospitals now keep their costs increases below 9 percent, voluntarily.

First, are these hospitals generally smaller or large institutions?

Secretary CALIFANO. 22.2 percent have their costs down below 9 percent; 28.3 percent of small hospitals—those with fewer than 4,000 admissions—keep their costs below 9 percent; 14.7 percent of the large hospitals—those with 4,000 or more admissions—keep their costs below 9 percent.

Of the Government hospitals, 26.3 percent are below 9 percent. Of the nonprofit hospitals, 19.4 percent are below 9 percent. Of investor-owned hospitals, 25.1 percent are below 9 percent.

Examples by region: in New England, 20.8 percent of the hospitals. In the South Atlantic, 18.7 percent are below 9 percent. In the Pacific area, 21.9 percent are below 9 percent.

Senator TALMADGE. How about by size?

Secretary CALIFANO. By size, as I said, the smaller hospitals, with fewer than 4,000 admissions, 28.3 percent are below 9 percent. Of the large, those with 4,000 or more admissions, 14.7 percent are below 9 percent.

Senator DOLE. Will you yield?

Secretary CALIFANO. Yes.

Senator DOLE. Are these the same hospitals each year, or is it a changing list?

Secretary CALIFANO. I cannot answer that. I do not think it changes very much. A lot of hospitals have driven the cost down. I can get you more detailed data on that, Senator Dole.

Senator DOLE. If it is a changing list, the list would not be very meaningful.

Secretary CALIFANO. I do not think it is.

Senator TALMADGE. Following on Senator Dole's question, are these the same hospitals with a percent below 9 percent? In other words, how many have kept their increase below 9 percent for 3 consecutive years?

Secretary CALIFANO. I will have to submit that for the record. Some hospitals are doing that.

[The following was subsequently supplied for the record:]

The Department recently completed a study which determined the number and types of hospitals experiencing annual increases in total operating expenses of less than nine percent for the period 1974-75, the most recent period for which complete data are available from the American Hospital Association. The findings were as follows:

18.2 percent of hospitals experiences increases in total operating expenses less than 9 percent;

25.4 percent had increases in total operating expenses per adjusted (for outpatient visit volume) admission less than 9 percent; and

19.7 percent showed increases less than 9 percent in total operating expenses per adjusted patient day.

Although many hospitals had cost increases below 9 percent, most hospitals did not. Groups of hospitals with the following characteristics had a less than average proportion of hospitals realizing cost increases below 9 percent for all three cost measures:

Hospitals with nonprofit, nongovernment type of control;

Hospitals with a northeastern location;

Hospitals with a metropolitan location; and

Hospitals with more than 4,800 admissions.

A similar study for the periods 1973-74 and 1972-73 is currently underway in the Department. As soon as the results are available they will be made available to the committee.

Secretary CALIFANO. I would also note that there are States that have rate commissions that your bill recognizes and which the President's bill recognizes, in which hospital costs, hospital rate increases, or hospital revenue increases, are held below 9 percent. Massachusetts is one, Maryland is another, Connecticut is now putting such a system in place,, Rhode Island, some other States.

Senator TALMADGE. You will submit that for the record?

Secretary CALIFANO. Yes.

[The following was subsequently supplied for the record:]

HOSPITAL REIMBURSEMENT RESEARCH

PROSPECTIVE REIMBURSEMENT

Prospective reimbursement encompasses those mechanisms of payment to health care providers which establish the rate the provider will be reimbursed

prior to the period over which the rate is to be applied. Traditionally, most health insurers, including Medicare pay hospitals and other providers retrospectively on the basis of their reasonable and allowable costs. While this policy guarantees coverage for almost all hospital expenditures, it provides little economic incentive to the hospital to moderate costs. Proponents of prospective reimbursement believe that the rewards and penalties built into such systems will motivate providers to allocate resources more efficiently without compromising the quality of their services.

Evaluations of nonfederally funded systems

When the Social Security Amendments of 1972 were enacted, several State and local prospective reimbursement systems were operating without Federal involvement. Consequently, the Division of Health Insurance Studies decided to conduct indepth analyses of several of these existing systems in order to determine where and how experimental resources should be concentrated. These analyses have attempted to determine the impact of prospective reimbursement on hospital administration, cost behavior, and quality of care through comparisons with matched control groups of hospitals and/or before and after time periods.

The seven operating systems selected for empirical study were those in western Pennsylvania, upstate New York, downstate New York, New Jersey, Rhode Island, Indiana, and Michigan. These systems had a variety of sponsors including Blue Cross plans, State governments, and hospital associations and employed one of five prospective payment methodologies—budget review, budget reviews by exception, formulas, negotiation, or some combination thereof. The evaluation of these systems will soon be available from the National Technical Information Service. At present, all but the Indiana and Michigan evaluations have been completed.

In general, the evidence from the analyses suggests that the prospective reimbursement programs have been moderately successful in lessening the pace of hospital cost inflation. These findings are significant in that they represent the first careful documentation in the United States that prospective reimbursement has a downward effect on hospital costs. Based on these results, seven elements have been identified which appear to be essential to an efficient prospective ratesetting program. These elements are as follows:

(1) All hospitals within a given system should submit accounting and reporting data based on uniform systems.

(2) Health planning and ratesetting should be closely coordinated.

(3) Prospective ratesetting systems should focus on total hospital expenditures including utilization factors.

(4) Prospective ratesetting systems should cover all payers.

(5) Hospital participation in prospective ratesetting systems should be mandatory.

(6) Statistical screens should be established to determine what hospital costs are reasonable.

(7) An appeals or exceptions process should be created to allow hospitals the opportunity to rectify what they believe to have been an inappropriate decision.

Results of the statistical measurements of cost savings achieved by the prospective reimbursement systems analyzed are summarized in table 1.

TABLE 1.—COST SAVINGS FROM NONFEDERALLY FUNDED PROSPECTIVE REIMBURSEMENT SYSTEMS¹

Program	Duration	Methodology	Voluntary/ mandatory status	Percent savings per year	
				Per day	Per case
New Jersey.....	1969-73	Detailed budget review.....	Voluntary.....	2-3	-----
New York (upstate).....	1970-74	Formula.....	Mandatory.....	1	2
New York (downstate).....	1968-74	do.....	do.....	4	2
Rhode Island.....	1972	Negotiated budgets.....	Voluntary.....	3.7	3.1
Western Pennsylvania ²	1970-74	Formula and budget review.....	do.....	4	2.6

¹ Excludes evaluations of the systems operating in Michigan and Indiana which are still in progress. Final reports are due by the end of 1977.

² Two-percent savings per year on total costs.

In viewing these results, it should be cautioned that many findings did not pass rigorous statistical significance tests. Even where statistics were significant, the 1- to 3-percent magnitude of savings attributable to prospective reimbursement would not suffice to bring hospital cost increases in line with inflation in other sectors of the economy. Nevertheless such savings compounded over time offer a substantial benefit to the economy.

Federally supported research experimentation

Between 1972 and January 1977 the Social Security Administration implemented five prospective reimbursement demonstrations involving waivers of Medicare reimbursement principles for short-term acute hospitals. Concurrently, over 20 other studies, developmental projects, and evaluative projects have been initiated. The focus of these activities has been on the hospital, for it is the hospital sector of the health care delivery system which has experienced the most precipitous increase in costs. Since the expiration of the Economic Stabilization Act in April 1974, the hospital service charge component of the Consumer Price Index (CPI) has risen at an annual rate of approximately 13.4 percent, as compared with the 7.5 percent increase in the overall CPI. Medicare's outlay for hospitals has risen commensurately.

In the past 2 years, DHIS's prospective reimbursement research and experimented efforts have expanded rapidly and entered a "second generation." Six new projects have resulted from a request for proposals (RFP's) issued in September 1975 soliciting offers to develop or implement prospective ratesetting systems. Two of these new contracts are operational: Washington State Hospital Commission and Blue Cross of Western Pennsylvania. The other four, to develop and/or refine prospective ratesetting systems, were awarded to the Massachusetts Rate Setting Commission, the New Jersey State Department of Health, the Blue Cross Association of New York and the Connecticut Commission on Hospitals and Health Care. SSA has also recently signed a two-phased contract with the Maryland Health services Cost Review Commission. These second generation ratesetting activities have incorporated and built upon experience gained from previous research. Each of these new programs is based on mandatory provider participation. The programs will be carefully monitored and analyzed to determine how hospitals would have behaved in the absence of specific prospective reimbursement models and to determine if broader mandatory statewide programs, including all payers, are more effective than earlier "first generation" systems in containing health care costs. Because the procedures used to set rates are perhaps the most transferrable features of ratesetting programs, these analyses will focus on comparison of alternative ratesetting methodologies.

The relationship of the ratesetting authority to other State agencies will also be studied to assess the internal structure of alternate ratesetting agencies. Some of these new programs may ultimately qualify for grants under section 1526 of Public Law 93-641. Under this authority, DHIS will examine the impact of ratesetting models which co-locate the ratesetting and health planning authorities.

In addition to these new ratesetting activities, DHIS will continue to monitor and evaluate a number of ongoing projects, including prospective reimbursement systems operating in Rhode Island, South Carolina, and Western Pennsylvania, and evaluate a number of ongoing projects, including prospective reimbursement at Yale University. The results of these reimbursement activities should provide the necessary empirical evidence upon which to base sound policy decisions concerning the financing, organization, and management of a cost-effective hospital and health care system.

Senator TALMADGE. In your testimony, on page 7, you state, "We do not have local wage-base data for most localities." I agree with you that this is an important variable in comparing hospitals.

Are you aware that during the drafting of this section we were advised by the Office of Research and Statistics of Social Security that such wage level indicators could be developed prior to the bill's effective date?

Secretary CALIFANO. I indicated that it would take a couple of years to respond to that, they are indicating by fiscal 1981. That's my ex-

perience—in fact, we talked about this just yesterday. We believe such data should be developed. We believe some other data should be developed as well. I think you are absolutely on the right track.

Senator TALMADGE. They gave us information last year that that data could be provided prior to the effective date. In your statement, you say that the Department will submit comments on the various sections of S. 1470 during the next several months.

As you know, most of the provisions of S. 1470 were contained in a similar form in S. 3205.

Last July, your department promised to provide us with comments on the various sections of the bill. I understand that, in fact, comments were drafted, but never submitted.

In view of the fact that essentially the same agency people who were operating medicare and medicaid are still running the programs and in view of the failure of it to submit promised comments last year, I expected that we will be marking up the bill during the next few months, rather than waiting around indefinitely.

Once, again, for HEW's possible reaction, do you think you could expedite those comments for us?

Secretary CALIFANO. You bet I will expedite them.

If I may make two other comments, first, we will expedite the submission of our comments. A lot of people are the same. But after the election, there is a different attitude in terms of hospital costs at the top of HEW today than there was in the past.

There are two other sections of the bill that I am prepared to comment on now so that you understand our view.

Regarding section 12, in which you would fold in the radiologists, anesthesiologists, pathologists and others, we believe they should be folded in under any kind of legislation in this area. As you know, Mr. Chairman, from other conversations that you and I have had, we feel strongly that they should be folded in, they should be covered. The day of getting a percentage of the gross, like Robert Redford, or big movie stars, has got to end for the anesthesiologists and radiologists and pathologists of this country.

We may have some technical amendments and ways in which we think we can deal with some of the inherent conflict-of-interest problems.

Senator TALMADGE. We would appreciate that.

Secretary Califano, I might say, incidentally, here, that all three of those professions have now agreed to accept a fee for service rather than a percentage of the gross receipts as has been customary.

Secretary CALIFANO. That is terrific.

The other thing that we have already been trying to move on to the extent we can administratively, and which we think is another way in which you have shown foresight, is found in section 20, in the conversion of hospital beds to nursing home beds in rural areas where those beds are clearly excess. We think that is important. We may have some suggestions for extending an enlarging on that concept.

This may be one way to use excess hospital beds in this country. There are 240,000 empty beds, 100,000 of which local agencies have determined to be excess. It is costing the citizens of this country \$1 to \$2 billion a year.

Senator TALMADGE. I could not agree more, Mr. Secretary.

One of my primary objectives in proposing the creation of the HCFA is to fix accountability, particularly in quality assurance activity. Even though a whole new layer of bureaucracy is being proposed in the new organization to deal with this matter, I am informed that approximately 22 medicare-medicaid related positions are being retained in the Public Health Service to review and sign off on the work of the Associate Administrator of Quality and Standards of the Health Care Financing Administration.

Further, while the PSRO program is being administered by the Health Care Financing Administration, PSRO policy, and the national PSRO Counsel, is to remain in the Public Health Service. Mr. Secretary, can you explain how you can fix accountability and responsibility when you have policy in one agency and operations in another?

Secretary CALIFANO. I do not think I have quite made that separation, Mr. Chairman. What seemed to me important, when I announced this reorganization in February, was to retain an element of quality control within the office of the Assistant Secretary for Health. We do that for two reasons. One, that office itself has programs over which it has control that need quality control, such as HMO's, community health centers, what have you. Some people must be kept there to watch them.

Second, it seemed to me that the broad health professional, medical doctor input was important to have on a continuing basis in the Health Care Financing Administration.

I want to make certain that the Assistant Secretary for Health, which I am trying to build and strengthen as an office, would be capable of providing the kind of advice that he would need to provide on the medical doctor's side to HCFA. That is why I left the organization that way.

Senator TALMADGE. The Bureau of Quality Assurance has its own doctor.

Secretary CALIFANO. I know that, Mr. Chairman.

One of the things that I think this part of the reorganization does which I think you are after, too, is the fact that we have pieces in health. pieces in SRS, and we have pieces in the Social Security Administration.

Senator TALMADGE. Scattered all over the lot.

Secretary CALIFANO. That is right.

We now pretty much have all the health pieces in health, and pretty much all the financing pieces in the Health Care Financing Administration.

I think the bridge—this sort of dotted line—organizational bridge between the Office of the Assistant Secretary for Health and HCFA, is important; at least for the time being we should have the capability in the Office of the Assistant Secretary for Health, with the medical doctors.

The medical doctors of this country and the health professionals in a very real sense look to that Office. They look to the individuals in that Office as the place to which they best and most effectively relate professionally. I wanted to make sure, at least for the time being, that that capability is there.

Senator TALMADGE. It seems to the committee, Mr. Secretary, that the split still continues with the reorganizational plan rather than with the accountability of one staff and one spot. Rather than getting into a controversy with you at this time, we will wait for the report of the Comptroller General and look at it further.

Senator Dole?

Senator DOLE. Thank you, Mr. Chairman.

I understand that in answer to my suggestion that the Comptroller General take a look at the reorganization, that you have no objection to that, though you would rather not hold off implementation.

Is that because it might disrupt your long-range program?

Secretary CALIFANO. I think that is right, Senator. We have been implementing it step by step for an extended period of time. There are 15,700 people and \$58 billion in programs involved, and it will all be completed in 10 days to 2 weeks. I just think we cannot do that. That will not inhibit acting on any recommendations that the Comptroller General has. As I indicated to you, one of the first things I did was sit down with the Comptroller General—

Senator DOLE. You sat down with him. Did he make any recommendations?

Secretary CALIFANO. I did it about 3 months ago, shortly after I became Secretary. He had suggestions in this and other areas and I think you will find, to a very large extent, that we have acted on many of the ideas that the Comptroller General has given us. Some of them are legislative ideas which we are still studying. Some of them are longer-range ideas.

Senator DOLE. Are these in writing so that they can be made available to the committee?

Secretary CALIFANO. No, I think he left me with books and material that I am sure you can get from him or me. I would be delighted to ferret them out of our records.

There may have been some comments about individual people and their capabilities which I would rather not submit, if you do not mind. All the substantive material about programs and problems and changes covered the whole area of HEW, covered civil rights, covered all facets of the Department, including this facet of it.

Senator DOLE. I understand the subcommittee will make that request of the Comptroller General and hopefully we will have it in 30 days. If he recommends changes, it is my understanding that you are willing to adjust to those changes.

Secretary CALIFANO. I would be happy to look at them.

Senator DOLE. Maybe we can look at them together.

Secretary CALIFANO. Yes, Senator.

Senator DOLE. I want to correct something here. You indicated since the election there has been a new feeling at the top. I think both Nixon and Ford also sought to contain hospital costs with a cap, and we rejected that, too. The only difference is that you have raised your cap to 9 percent. Theirs was 6.7 or 7 percent. They did not do much better than you are going to do, and I think, based on the lack of enthusiasm for your bill, could it be presumed that you might be willing to go along with something like Senator Talmadge's bill?

Secretary CALIFANO. I do not think, Senator, that we can sit and wait without putting some cap on hospital costs. I think that we are in a

situation where we have an industry that is immune from all of the traditional incentives of our system.

I think that we have to have the 9-percent cap. If we do not, between now and 1981, we will spend an additional \$18.8 billion, cumulatively, as Senator Kennedy has pointed out. I think it is imperative to have that cap. My own judgment is that the only alternative is to have some kind of additional taxes on the American people. I do not think that makes sense.

As I have said repeatedly, there is plenty of fat in hospitals. We identify it in the appendix here: \$5 billion of fat, out of which we are only seeking \$1.9 billion in the first year.

Senator DOLE. Senator Talmadge, of course, does not agree. He sees some savings before 1981 in the Talmadge bill. I think perhaps we can reserve judgment on that.

It seems to me, even if the cap were enacted, you are not separating the efficient from the inefficient operations. You talk about fat hospitals, it seems to be the survival of the fattest. They are going to get the increase, just as the efficient hospitals are going to get the increase. That is the reason for some of the resistance in addition to the argument, how can you guarantee that the hospital costs are going to remain at 9 percent. Do you have that worked out?

Secretary CALIFANO. Let me deal specifically with respect to hospitals that are now increasing at more than 9 percent—and a lot of them are way over 15 percent. We are dealing with some very obese hospitals. We will bring them down to 9 percent, so we would hold them down.

Secondly, with respect to hospitals that are below 9 percent now, they have incentive to become more efficient. The hospital that we do not catch is the hospital that today is charging, say, \$300 or \$400 for a room and should be charging only \$250 for a room. We do not catch that \$150.

We think that hospital should be knocked down to \$250, but we do not know enough about the bed mix of hospitals, about area wage rates, about a whole host of other things, to do that.

If you are interested in getting after that hospital as well, we are delighted to agree with any legislative proposal that you have to knock that hospital down, but the other hospitals we catch. Senator Talmadge's bill would begin to deal with that hospital with his prospective reimbursement formula in terms of averaging out the classifications of hospitals.

We realize that. We want to get the data we need to do that as fast as we can.

The concern that we have on the other side with respect to the prospective reimbursement system is it does not do anything to stop the hospitals from continuing going up in their mean averages by 15 percent a year. So neither bill is a perfect world. It is not a simple problem.

We are trying to do our best to deal with this problem. We think that we have gotten as much of it as we can, and at the same time be eminently fair to the hospitals. We are letting their revenues increase by one and a half times the rate of inflation, and we think that is a fairly generous amount, especially with all the waste and inefficiency and excess capacity that there is.

Some of it is tremendous. In Houston, Tex., which has a very well-planned hospital system, the most modern hospital bed in a private room is \$85 a day.

In Miami, Fl., which abounds with excess hospital beds, old hospitals, the rates are more than twice that. They are running at about \$180 to \$190 a day for a private room. There is a tremendous amount of waste in this system that does not do anything except increase the taxes on the American taxpayer and increase the bills on the poor people who have to buy their own health insurance.

Senator DOLE. That is probably correct, but if you describe some of the hospitals as fat, what adjective do you use to describe HCFA? Is that lean?

Secretary CALIFANO. I think HCFA will be the Jack Sprat of Government organizations by the time we get it off the ground.

Senator DOLE. You are going to have a 9-percent cap on supergrades?

Secretary CALIFANO. Actually, Senator Dole, there are 28 supergrades available to move into HCFA. We are only moving 22 in for sure. Another five may go to the regions.

At most, they would be the same.

Senator DOLE. Thirteen existed before. Nine percent of that would be two.

Secretary CALIFANO. Thirteen supergrades existed in the medicare and medicaid bureaus and quality control bureaus. There are an additional set of 15 supergrades that come from the central office of SRS and elsewhere. We are moving the grades in. We are not moving the people in. Not all of the people are qualified for these jobs. It is very important to get qualified people.

Senator DOLE. Who is writing the job descriptions for these?

Secretary CALIFANO. Someone other than me, after the job description that I wrote for my own chef. I have retired from that business.

Senator DOLE. I just read the job description for the No. 3 man. You probably could use him somewhere.

What about Mr. Ruff? What brings him to the Department? His great work last year?

Secretary CALIFANO. In trying to determine what qualities we needed for the Inspector General and Deputy Inspector General, reviewing the hearings that this subcommittee held and that the Fountain subcommittee held in the House, we need two kinds of skills. One, we need, if you will, a Comptroller General kind of skill, someone sophisticated in efficiency, economy, government—and I asked Tom Morse to be the Inspector General. He had 5 years in the Pentagon in these areas and 5 years in the Office of the Comptroller General in developing efficiency systems, efficiencies, and economies.

Also, he studied the delivery of human service care services at Brookings for a couple of years, where he reorganized the Florida government. That was one set of skills.

It also seemed to me that directed at the fraud problem we needed the legal skills, we needed some criminal investigative skills and some prosecutorial skills. I went after and am delighted that I was able to attract Mr. Ruff to be the Deputy Inspector General and bring in that set of skills.

I think the combined sets of skills are what I believe are needed in our office and from our review of the legislative hearings.

Senator DOLE. What are his skills?

Secretary CALIFANO. I think his skills in a technical sense are his proficiency as a lawyer.

Senator DOLE. He embarrassed President Ford last year and myself. Beyond that, does he have any skill?

Secretary CALIFANO. He has skill as a criminal lawyer, as a professor at Georgetown University, as a prosecutor. I am not familiar with your personal relationship with Mr. Ruff. My best judgment of him is he is first class for that job.

Senator DOLE. He will be coming to this committee for confirmation?

Secretary CALIFANO. This committee or Human Resources, I do not know. I am sure you can have him any time you want him.

Senator DOLE. I just raise that question, it seems so many of the people in the prosecutor's office are winding up in the administration. I did not know they were a bit partisan. I assume they are not hired on that basis.

Secretary CALIFANO. Let me say, Senator, he was not hired on that basis. I have no idea what his politics are.

Senator DOLE. He is a Democrat.

Secretary CALIFANO. I am glad to know that.

Senator DOLE. I wouldn't want you to go 4 years without knowing.

Secretary CALIFANO. Senator, you should be a Democrat. You have a great sense of humor.

Senator DOLE. I want to protect minority rights. I will stay where I am.

I just have one other question. I may have some more later.

In one area that you address, there may be good reason for it, you allow payment for wage increases to nonsupervisory employees without limit. You touch on that in your statement. Maybe it is necessary. I do not know. You explain that it is because some are in the lower pay category.

Has that been studied and surveyed and justified?

Secretary CALIFANO. Yes.

Our basic justification—we looked at the problem and there are several kinds of problems. One is to try to get lower paid workers to stick for longer periods on the job. Second, to try and get them a little better trained. Some of those workers desire to do that. A lot of them are handling patients. A lot of them provide part of the comfort that can be very important to a hospital patient.

We also looked at the economic impact and, over the last 6 years, those wages have risen on an average of 7.2 percent a year.

We found that there may be several situations, particularly the first time a hospital recognizes those workers, either as an organized body for the first time, or the first time a hospital deals with those workers where there might be a need for a significant wage increase. We did not want to hurt them.

We also noted that on the average, hospital workers are 15 percent below nonagricultural workers in terms of pay in our economy. We thought this exception was justified.

Senator DOLE. I do not quarrel with that.

They are also organized. Is there any more justification for that exemption than, say, any increase in drug costs or fuel costs or other necessary costs that may or may not be in the control of the hospital?

Secretary CALIFANO. We thought there was, for the special reasons I noted. As far as fuel costs are concerned, I would make two points——

Senator DOLE. I think you indicated they could save up to 20 percent.

Secretary CALIFANO. There are two points. Our studies indicate that within a year or so hospitals can be saving about half a billion dollars a year if they were just more efficient.

Second, the energy cost piece of this will eventually have to be related to the energy legislation that is working its way through the Congress, in which there is provision to ease this problem to some degree with respect to hospitals.

As far as the other costs, we really thought that this 9-percent cap would make the hospital administrators a little tougher negotiators on a lot of things.

Senator DOLE. I certainly understand your dedication to try to do something about it. We commend that.

I think, as you point out, if you carry out your program you might save \$1.9 billion or something in that area, more billions than that over the years.

I am hopeful that, at the same time we are talking about hospital costs, we are talking about administrative costs and the costs to the taxpayer because of HEW or Agriculture or whatever it is. That is the other half of the coin.

Secretary CALIFANO. I agree 100 percent. I really devote a lot of time to try to trim administrative costs in HEW, not just in this area, but in other areas as well, to try to get a systematic procurement policy in place, just to try to get the Department better managed. I am not saying that it can be done overnight.

There are a whole host of problems, but we are trying to do it as fast as we can. Also, not unrelated, I might say, to the personnel issues here, is the fact that there are almost 16,000 employees involved in the whole reorganization. There are a host of rights they have under laws passed by the Congress, and the Civil Service Commission provides some inhibition on the flexibility that you or I might, in any particular case, wish to recognize.

When you see it all—as I said, I am delighted to have Mr. Staats and his people look at it, and they may even have better ideas than they had previously suggested, or that we have had. I am delighted to get it rolling. I think we can use all of the help available in getting better management.

Senator DOLE. Thank you.

Senator TALMADGE. Senator Danforth?

Senator DANFORTH. Mr. Secretary, let me see if I can summarize your position.

You view the 9-percent lid as a temporary stopgap method until some permanent cost containment program is in place?

Secretary CALIFANO. That is correct, Senator.

Senator DANFORTH. The permanent cost containment program may turn out to be the kind of program that Senator Talmadge has offered, or it may turn out to be something different. Your view is rather than having Congress push forward and pass this particular bill, you

would rather keep your options open and see what will be developed over the next 9 months?

Secretary CALIFANO. I would rather state that a little differently. There are some elements of Senator Talmadge's legislation that we think are good and we would like to see move promptly, such as the elements I mentioned related to radiologists, anesthesiologists, and the very adept manner in which he is attempting to provide incentives to convert excess hospital beds to nursing home beds or other health facilities where they can be used for that purpose.

Also, we like the idea of prospective reimbursement very much. Our concern about prospective reimbursement is how fast we can develop the kinds of sophisticated data that we want that is necessary for that.

I am not, here, saying "stop" on the Talmadge bill, roll our bill through and we will all look at it a year or two from now. We would like to make technical suggestions on this legislation because there are a lot of aspects of it that are good.

I do think I did mention a couple of specifics, such as the profit point, and the medicare payment to doctors secrecy point which the chairman agreed with. Also, I would not want to see detailed legislation on the Health Care Financing Agency, quite frankly. When you start a new agency, you are moving 4,200 people around. It is going to take a year or two to get it on the books, to get it as lean as it ought to be.

I think at that point in time we need flexibility. We need all the watching that I am sure the subcommittee and others will give us, but we need flexibility to put that in place.

Senator DANFORTH. Let us concentrate on the reimbursement problem.

It is your view, I think you said, that this problem is the leading contributor to the increased cost in health care.

Secretary CALIFANO. Hospitals are going up faster than anything else in this arena. That is right.

Senator DANFORTH. The reimbursement problem is right at the heart of the total concern.

Secretary CALIFANO. Yes.

There are other pieces. The fact that we do it retrospectively hurts, because we are operating in a cost-plus world in which you just put in your CAT scanner and every hospital has every piece of expensive gadgetry that it wants, and we just come along and pick up the tab.

Senator DANFORTH. That is a somewhat different problem. That is a capital acquisition problem.

Secretary CALIFANO. It is a part of this, Senator. We, in effect, end up picking up the tab. They are depreciating that equipment, so we are also picking up overhead charges on that stuff.

Senator DANFORTH. I understand that. What I would like to focus on is the reimbursement problem, per se, rather than any limitation on capital acquisition, or way of financing capital acquisition.

It is my understanding that your view is that the method of reimbursement is very much a part of the problem.

Secretary CALIFANO. That is correct. We feel, if in the short run we can say to a hospital administrator, you may have 9 percent more revenues next year than this year, but that is the extent of your increase in reimbursement. You know that now, go plan your year, and we believe that that will have a tremendous impact.

We think that both the Talmadge bill, and our bill are in effect prospective, in that they both say "this is what you are going to get in the future."

Senator DANFORTH. They are very different approaches. The 9 percent is saying, here is your total revenue. The Talmadge proposal is to say, calculate your estimated revenue and, if you go 20 percent over that, we are not going to pay you the overage. If you go under that, we will give you some sort of financial incentive.

Secretary CALIFANO. In the Talmadge proposal, if you go under it by 90 percent, you get half of that. You are allowed to keep half of that.

In our proposal, if your admissions are as much as 6 percent less than they were in the prior year, you are allowed to keep all of that money. So there are incentives on that scale.

In both bills, I think ultimately in the long run, Senator, we are going to end up with all the caveats. We are going to learn a lot in the next couple of years. We are going to end up with a system of prospective reimbursement similar to what Senator Talmadge is suggesting with some kind of a cap.

His does not pick up the cap part, just as ours does not pick up that hospitals charging \$400 a day that should be only charging \$250.

Senator DANFORTH. Reimbursement, whether it is prospective reimbursement then adjusted at the end of the year, or whether it is retrospective reimbursement, is still essentially payment for piecework, is it not?

Secretary CALIFANO. I guess you could characterize it that way.

Senator DANFORTH. Let me ask you a question. Is this not a part of the problem?

Maybe we should not be dealing with medical care as though it is piecework. Maybe we should be making grants to hospitals, even grants to physicians, of a lump sum. That is in essence what the 9-percent lid does. Then we can say to them, look, we are tired of all of the paperwork. We are tired of the kind of approach where the more you do the more you get paid, the kind of overutilization of health care, which apparently we have now. What we are going to do is simply give you a lump-sum payment and you are the professional, you make the decision as to what kind of service you want to render.

Secretary CALIFANO. I would say "hurray" to that. That is exactly what we are trying to do. We are saying, you will get this much money next year, Mr. Administrator; how you are going to get it is all in your ball park. What you are going to do with your board of trustees, what kind of equipment you are going to buy, whether you are going to realize savings here or there, or what have you, it is all yours to decide.

Also, in the context of paperwork, there is not a single additional piece of paper that you have to file under this system unless you want to come in for some kind of special exemption, and that would only be in a situation where you are really, essentially, over or under 15 percent.

That does make sense, at least in the context of what we tried to put together.

Senator DANFORTH. Is it politically possible, or is there going to be a continuing demand, for the Government to audit what doctors do,

audit what hospitals do, make them justify on a case-by-case basis on payments received?

Secretary CALIFANO. The difficulty is in finding a way between throwing money away because you are inefficient and you are not carefully enough monitoring what the taxpayer's money is being spent on, and trying to develop a system where we can delegate the fiscal responsibility, and say to somebody, "you are the expert here." This dilemma runs through every program we have got.

We have to find ways, very candidly, over the long haul, over lots of programs, to effectively audit on a sample basis, the way the IRS does, and get out of the business of sitting over everybody's shoulders with a green eyeshade trying to figure out whether when he added two and two and got five he was defrauding us or just made a mistake.

Senator DANFORTH. Your concept is, instead of the present system of paying x number of dollars for, say, an appendectomy, we would be in the business of paying a hospital x number of dollars for caring for people who need to be cared for?

Secretary CALIFANO. We would, in a sense. This would be self-enforcing in the sense that the third party payors would also restrict their payments to this point. There are provisions in the administration's bill, where we would make public, for example through the health systems agencies, the cost of hospital services or stays in hospitals—putting a little sunshine in where there was darkness, putting in a little of the free enterprise system.

There is at this time an utter lack of competition. I realize we are not selling shoes or automobiles, but the fact is, another aspect of the current reimbursement mechanism, Senator, is that the person who is getting the service is not paying for the service. In 90 percent of the cases, the patient does not pick the service. The doctor tells him what service he needs or his mother needs or his child needs and he does not pick where he is going to get it. The doctor says, go to this hospital; that is the hospital that I am associated with. I would like you to go here.

So there is no incentive of any kind, as there are in other aspects of American life, to be efficient. Within that context, the patient, the purchaser, really does not have any incentive. Either his employer is picking up the tab for his health insurance, or he does not notice it when he pays each month, or medicare or medicaid is picking up that tab.

We had hoped——

Senator DANFORTH. The worst kind of disincentive to economy is to tell the hospital, we do not care what you do. We are going to pay you.

Secretary CALIFANO. Right.

Senator DANFORTH. We are presently in the business, are we not, of financing capital construction and financing the acquisition of equipment.

Secretary CALIFANO. Yes, we are, Senator.

Senator DANFORTH. By reimbursing for interest paid and depreciation.

Secretary CALIFANO. We do that, and also we build some hospitals. We also finance them. We also, through HUD, provide guarantees.

Senator TALMADGE. May I interrupt briefly?

There is a record vote in the Senate. How long do you intend to interrogate?

Senator DANFORTH. One minute.

Senator TALMADGE. Senator Dole?

Senator DOLE. I have one question.

Senator TALMADGE. May I make this suggestion, then?

I will ask Senator Dole to preside; I will go vote. Senator Danforth can complete his interrogation of the Secretary, you complete yours. I will return immediately from the Senator floor and we will continue the hearings.

Is that agreeable?

Thank you very much, Mr. Secretary. If you will excuse me at this point.

Senator DANFORTH. Mr. Secretary, do you think we should continue to be in the business of paying for building and equipment?

Secretary CALIFANO. In very limited circumstances. I do not think by and large we should be in the business of increasing hospital beds. That makes no sense at all, because we are paying for it. We just keep paying for all those idle beds.

I do think there may be situations in which there might be two or three old hospitals which can be renovated. The VA, for example, out on the west coast is building, but they are combining a couple of hospitals, actually reducing the number of beds and hopefully putting in a more efficient facility.

We have, in our bill, a \$2.5 million capital expenditure cap. I hope that will provide some incentive to hold this down. I think that it is rare that we should be in the business of building any more hospital beds.

Senator DANFORTH. The alternative to the cap, of course, is to say, we do not care what you do. We are not going to pay you for it.

Secretary CALIFANO. There is enough local money out there. What we would have to do is say, not only are we not going to pay you for it, but if you go to that hospital you are not going to get medicare and medicaid payments.

I think we could end up with an overly complicated system if we get into the business that where there is a new wing of the hospital, we would ask how much does that wing add to the cost?

That is the problem.

Senator DOLE. Mr. Secretary, maybe you can supply an answer to this question. It is regarding the need for physician practice in low shortage areas found in section 11.

There was a section in S. 3205 last year, at that time HEW was not prepared to respond to that. If there are any comments or suggestions on that provision, I think it would be helpful to have it for the record. I do not think you have responded to it.

Secretary CALIFANO. I will provide it for the record.

I would note generally, Senator, that I realize you have been, and are, a proponent for increasing physician services in rural areas. We agree with you. We recognize that need. The President has proposed legislation which would bring within the gambit of medicare payments physician extenders and nurses.

Basically, we have increased, and hopefully will soon have in place and ready to go, our National Health Service Corps and our financial

aid for medical students to try to encourage more and more of them to go into rural areas.

It is important to do this, and we will look at this issue and respond constructively.

Senator DOLE. Now, throughout your statement you describe the lack of necessary methodology for comparison of hospitals and hospital costs. If that is the case, how long do you think that it will take to develop the necessary expertise?

Hospitals are very concerned. It is not 9 percent a year, sort of a ratcheting effect, as I understand it, a very complicated formula that may be less than 9 percent in the second year.

I guess the second part of that question would be, do you intend, with your so-called short interim controls, to apply them indefinitely until you are satisfied that you have the expertise?

Secretary CALIFANO. We would like it to apply until we have in place a more sophisticated and permanent system. I think that we should be working and we are, I hope, working on getting the kinds of information, such as wage area rates, or some simple but fair system of determining what bed mixes there are in particular hospitals, or some fair way of figuring out what are teaching hospitals. There are between 1,100 and 2,000 teaching hospitals in this country. Some teach one course. Some are full-blown medical school-related hospitals like Harvard, Johns Hopkins, or Georgetown.

There are also questions of accounting systems, questions on things like that.

Ours is a transitional proposal. I think we can do better with a more permanent system.

The whole thing is not unrelated to what kind of a system of national health insurance over what period of time this Nation ultimately decides to adopt.

Senator DOLE. Do you have any notion at this time as to how long it will take?

Secretary CALIFANO. To get some of the information here, Senator Talmadge indicated that there was a feeling that the wage area rates, for example, could be in place by 1981. I will be happy to submit our best estimate on that for this committee for the record.

[The following was subsequently supplied for the record:]

It is anticipated that adequate data to classify hospitals in a desirable manner will be available as follows:

1. area wage data : 1 year.
2. teaching hospital/medical center hospital : 1 year.
3. bedmix/casemix : 2-4 years.
4. Uniform accounting system implementation : 2 years.

The effort of implementing a classification system includes not only resolving any data availability problems but also determining how the data should be employed in reimbursing hospitals. Research is continuing in each of the areas above.

An area wage index may be developed from each of several sources, several labor categories, and several levels of aggregation. A report presenting the alternatives will be prepared by September 1, 1977. The teaching hospital definition most commonly used in HCFA research has been any short-term general community hospital with (1) a ratio of interns and residents per bed greater than or equal to 0.10 and (2) a major medical school affiliation listed in the Medicare Provider of Services File. Regional Offices of SSA should be able to certify hospitals as medical center hospitals under this definition. No more than 400 hos-

pitals are estimated to be designated medical center hospitals under this definition. The acceptability of this definition has yet to be tested.

The bedmix/casemix measures will take 2 years to develop due to the current lack of experience in defining hospital casemix. Developing a reliable casemix index which measures the degree to which hospitals care for severely ill, resource-intensive patients will require advancing the state of the art. Three projects are being initiated in HCFA to test the validity and feasibility of using Medicare casemix information to infer generally the casemix difficulty of the entire hospital patient load. The relation between the best casemix measure(s) and hospital care costs will then be examined. A data collection system whereby every hospital classified must reveal the number of discharges and patient days by discharge diagnosis plus additional patient information such as average age by diagnosis number or surgical procedure performed, etc., may be considered.

A uniform accounting system has been developed by HCFA and could be published in the Federal Register, after responses from interested parties and subsequent revision, six months from a "go ahead" date. This system will solve many problems associated with hospitals having different accounting systems if implemented throughout every hospital.

Senator DOLE. I do not want to belabor the Comptroller General's point. I do not intend to imply any criticism of what you have been able to do with the reorganization, but I think that it would be helpful, and we will pursue the Comptroller General route, just as a matter of being totally objective and thorough, but if he should make recommendations, I want to get back to the question, can we expect some action on those?

Secretary CALIFANO. I will act upon any good recommendation that he makes.

Senator DOLE. I do not always agree with the Comptroller General, either.

Secretary CALIFANO. Obviously I have to reserve the right and the responsibility to look at them carefully in the context. From my vantagepoint, people can disagree about how best to put an organization together, but as I said, I have found Mr. Staats and his people in this area and other areas related to HEW to be very good. They provided a lot of helpful suggestions to me the first few weeks I was in office.

I would expect to work closely with him, and I would be happy to have him look at this or any other part of the reorganization. They provide a very important service indeed. They are my model for what I would like to see my Inspector General's office be. I would like to see that be the internal control for HEW.

Senator DOLE. I think they do do, for the most part, an excellent job.

Senator Talmadge touched on another matter that physicians are concerned about. You referred in your statement to developing controls on the costs of physicians' service. I think you may have addressed that indirectly in response to one of Senator Talmadge's questions.

Could you share with us any specific, or even general ideas that you have along these lines?

Secretary CALIFANO. We really do not have any specific ideas. As I said, there was a proposal suggested earlier in the year to the President and to me. We rejected the proposal at that time because we did not think we knew enough about it to make a fair judgment as far as doctors were concerned.

I think the only fair thing for me to say is that we just do not know yet how to deal with the problem.

Senator DOLE. I understand, Mr. Secretary, that Senator Talmadge has no further questions and I have no further questions.

We deeply appreciate your appearance. You may be excused. I will go over and vote.

We will stand in recess until Senator Talmadge returns. I look forward to seeing you again.

Secretary CALIFANO. I am sure that you will, Senator.

[The prepared statement of Secretary Califano follows:]

STATEMENT BY SECRETARY JOSEPH A. CALIFANO, JR., DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE

Mr. Chairman, I appreciate the opportunity to appear before this distinguished Subcommittee on Health to discuss S. 1470, the proposed Medicare-Medicaid Administrative and Reimbursement Reform Act.

By introducing this legislation, you continue the Finance Committee's tradition as thoughtful critic and powerful force for reform in this nation's health care system.

Your Committee's concern with development of a comprehensive health care policy for all Americans—especially for those who are poor, or aged or disabled—dates to the 1930's and the original maternal and child health program.

Since then, you have been instrumental in health care innovation and policy-making with such measures as vendor payment programs supporting medical assistance to the poor and aged in the 1950's and early 1960's; the development and expansion of Medicare and Medicaid; and the design of other landmark health programs including Professional Standards Review Organizations.

Last session, the Finance Committee, through this Subcommittee, again provided leadership in identifying serious problems and devising needed reforms in the nation's health care system.

In less than six months in office, we in the new Administration have moved to support or to implement the most urgent of those reforms.

First, in the 94th Congress, you introduced legislation to remedy serious problems created by fraud and abuse in the Medicare and Medicaid programs. You recognized that fiscal integrity and sound management practices must characterize these programs if they are to enjoy the trust and confidence of the American people.

This year the fraud and abuse legislation has been introduced separately in both Houses of Congress, with strong endorsements from the President and from me. That legislation should soon pass the House and we look forward to the opportunity to urge its passage in the Senate.

Second, your health care reform legislation in the 94th Congress proposed establishment of an Inspector General for Health within the Department of Health, Education, and Welfare. That proposal—expanded so that the jurisdiction of the Inspector General includes all programs of HEW—became law last year, and we have acted quickly to implement it. The new Inspector General, Tom Morris, and Charles Ruff are men of superb qualifications who have been moving swiftly to organize this office and to begin the vital work of reducing fraud and abuse in HEW's programs, especially in the Department's health programs.

Third, you have proposed, both last session and in the present Medicare-Medicaid Administrative and Reimbursement Reform Act, that the health care financing functions of the Department be consolidated into a single administrative structure.

President Carter endorsed this concept early in the presidential campaign. As you know, less than sixty days after assuming office, I effected this much needed reorganization through administrative action. As I noted at the time of the reorganization, we are deeply indebted to the work of this Subcommittee, and to the illuminating hearings that you held last year on the problems of health care financing.

We have high expectations for this element of the Department's reorganization. The Health Care Financing Administration should significantly improve the effectiveness, efficiency and responsiveness of Medicare and Medicaid by coordinating the policy and practices of the two programs and by eliminating, or reducing, unnecessary and costly duplication in their operations. By joining

these programs under one administrative structure, we should also realize important economies through reduction of fraud, abuse and leakage.

Under the leadership of Robert Derzon, one of this nation's outstanding hospital administrators, we are trying to make HCFA operational as soon as possible. In the short term, we must take the separate Medicare and Medicaid functions and employees and weld them into a cohesive unit.

We believe that the structure presently contemplated is an appropriate first step in the development of a sound HCFA organization that will be fully content with the intent of your health care financing proposal. At this time, it is essential that we continue to have flexibility to adapt organizational structure to the programmatic needs that emerge from practical, day-to-day experience. We do not, therefore, believe that legislation establishing HCFA is necessary to achieve the desirable goals of consolidating Medicare and Medicaid administration.

HOSPITAL REIMBURSEMENT AND HOSPITAL COSTS

Mr. Chairman, there is another problem identified in the proposed legislation that the Administration views as being of the greatest urgency—the methods by which hospitals are reimbursed for services provided to Medicare and Medicaid beneficiaries and the skyrocketing increases in hospital costs that are caused, in substantial part, by present reimbursement methods.

I would like to devote much of my remaining testimony to this fundamental issue because it is a matter of signal importance and because the President has proposed legislation, the Hospital Cost Containment Act of 1977, that also addresses the problem. As you noted when introducing S. 1470, the Administration bill is a transitional measure that complements the long-term, structural reform contained in the Medicare-Medicaid Administrative and Reimbursement Act.

As this Subcommittee knows well, the Medicare and Medicaid programs presently reimburse hospitals for reasonable costs incurred in providing services to program beneficiaries. This retrospective payment method has proven to be highly inflationary because reimbursement simply covers rising hospital costs, however unnecessary or wasteful those costs may be. By reimbursing hospitals for most incurred costs, this method provides virtually no incentives for efficiency.

As this Subcommittee also knows well, this method of reimbursement—which also applies in other health programs—has contributed to rampaging inflation in the hospital industry (which constitutes 40 percent of health care costs). If we take no action now, total health expenditures will double between 1975 and 1980; hospital costs paid by Medicare and Medicaid will double even sooner: total hospital spending could reach \$220 billion by 1986; and the share of the federal budget that goes to hospitals will rise steeply above the present 9 cents of every Federal dollar.

Section Two of S. 1470 would establish a prospective reimbursement system for hospitals participating in Medicare and Medicaid. In essence, this is accomplished by classifying hospitals according to bed-size and type and by establishing prospective limits on per diem routine operating costs for hospitals in that group.

We believe that the concepts underlying Section Two of the proposed legislation are sound and another testament to this Subcommittee's foreight: reimbursement of hospitals must be shifted from retrospective to prospective; prospective limits on hospital costs should be based on different types of hospitals; and these limits should encourage efficiency and penalize inefficiency. These concepts, as the President has stated, must clearly be part of meaningful reform.

But, although we support the concepts underlying Section Two's hospital reimbursement requirements, let me share with you some of the difficulties we have with that provision as presently drafted.

First, the provision applies only to Medicare and Medicaid payments, which constitute about one-third of hospital spending nationwide. Holding down Medicare and Medicaid payments alone could simply encourage hospitals to refuse these patients, to provide such patients with second-class care, or to transfer their costs to other payors.

Second, we do not yet have adequate data or methodologies to classify hospitals according to relevant cost-based characteristics—and such a classification is, of course, necessary for a sound long-run prospective reimbursement system.

Although Section Two significantly improves on the present method of classifying hospitals—which is required under Section 223 of the Social Security Amendments of 1972—by using local wage base data as an important variable, we simply do not have such data at present for most localities in the United States.

A sound classification system should take into account not just bed size and types of hospitals (as proposed in the bill) but also the types of patients in hospitals of equivalent size and type. Obviously a 200 bed short term general hospital with a large fraction of obstetrical patients will have different costs than a 200 bed short term general hospital with a large fraction of cardiac patients. Unfortunately, we presently lack the methodology to classify hospitals by types of patient (i.e. by the type of diagnostic patient case mix).

Similarly, the bill proposes that “teaching” hospitals constitute one of three “types” of hospitals (along with short term general and speciality hospitals). Again, we presently lack an agreed upon methodology for determining whether, and to what extent, an institution is a “teaching hospital.”

We do not believe that these are insurmountable barriers to a sound prospective reimbursement classification system, and we look forward to working with you to develop such a system. But these difficulties are real obstacles in the short term.

Third, and related to the point immediately above, Section Two only covers about 35–40 percent of present hospital costs and does not include such critical expenditures as capital costs, education and training costs, malpractice insurance expenses, energy costs, and so-called “ancillary costs” (e.g. the costs for expensive operating rooms or high-priced x-ray machines). Hospitals may be able to circumvent Section Two’s restraint on a limited proportion of their costs by shifting costs to other, uncovered areas (e.g. ancillary costs) or by increasing the lengths of patient stays.

Fourth, we seriously question whether a specific classification system should be actually written into a statute. Even when we are able to devise an adequate classification system for prospective hospital reimbursement, we will be continually refining our data and methodologies. Flexibility should be built into the statute to allow for improvements without additional legislation.

Fifth, Section Two does not place a limit on actual increases in hospital costs over time, but instead bases its limits on the average costs for types of hospitals. Thus, if all hospitals increase their costs substantially from one year to the next, this provision would permit reimbursement to rise accordingly.

Finally, Section Two, while pointing the way towards sensible changes in reimbursement techniques, will not, in our judgment, effectively control costs in the immediate future. Indeed, our preliminary, relatively conservative estimates indicate that Section Two could cost up to \$50 million more in 1978—even if it could be fully implemented—than the present cost limiting provision already in law. Not only could Section Two add as much as \$50 million to President Carter’s fiscal year 1978 budget, but its costs appear to increase with time—to approximately \$55 million in fiscal year 1979, \$64 million in fiscal year 1980, and \$75 million in fiscal year 1981. If modifications could be devised to meet the difficulties discussed above, however, then we would expect substantial long-term savings from Section Two.

For these reasons, Mr. Chairman, I share your views that the President’s proposed Hospital Cost Containment Act of 1977 is complementary to S. 1470. The Administration’s cost containment proposal is a transitional program, designed to restrain the intolerable current rate of increase in hospital costs and to gain the time necessary to work out some of the difficulties that we see in the present version of Section Two’s hospital reimbursement reforms.

As you know, the President’s bill limits increases in total hospital inpatient revenues to an annual rate of about nine percent, beginning in October 1977. The program would cover the inpatient revenues of about 6,000 acute care and speciality hospitals, but exclude long-term, chronic care and new hospitals.

The basic limit would be set by a formula reflecting general price trends in the economy with an increment for increases in services. Each cost-based third party payor would apply the limits in interim and final payments, and would monitor hospitals for compliance with respect to its own subscribers.

Under present estimates, the savings resulting from implementation of the Hospital Cost Containment Act would be approximately \$1.9 billion in fiscal year 1978—including \$657 million in Medicare and Federal Medicaid and \$879 million in private funds. By fiscal year 1980, net savings would nearly triple to over

\$5.5 billion, including \$2.0 billion in Medicare and Federal Medicaid and \$2.6 billion in private funds.

Thus, Mr. Chairman, as you stated on May 5, 1977, when introducing S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act "represents a long-term basic structural answer to the problem of rising hospital costs, whereas the Administration is calling for a short-term interim cap on revenues to be in place only until a long-term solution can be established." We recognize that our proposal is only a short-range measure, but it is no less necessary for being short-term and can serve the critical function of simply, quickly and effectively curbing the intolerable rise in hospital costs.

While I will not attempt to describe the Administration's cost containment proposal in any great detail at this time, Mr. Chairman, I would like to take this opportunity to respond to several specific questions and concerns you expressed about the Administration proposal in your statement introducing S. 1470.

You expressed concern that the administration proposal might establish a floor rather than a ceiling.

But I do not believe that hospitals will increase their revenues to the 9 percent allowable limit under our program. Experience with the Economic Stabilization Program indicates that a substantial fraction of hospitals kept costs and revenues within the limits imposed and did not automatically increase them to the maximum extent allowable. Similarly, approximately one-fifth of all hospitals now voluntarily keep their cost increases below 9 percent annually even though they are not required by law to do so. Moreover, under our plan, we have included provisions which would reward those hospitals coming in below the limit in any given year.

Mr. Chairman, you also indicated some concern that our exceptions are excessively generous.

We believe that we have restricted exceptions to only those conditions genuinely meriting some flexibility. There are only two basic grounds for exceptions—major changes in patient loads (more than a 15 percent increase in admissions) and major changes in new capital facilities or equipment. In both cases local health systems agencies would have to approve exceptions. The hospital would also have to demonstrate that it had current assets less than approximately twice its current liabilities, and therefore was in need of additional revenue to make those major changes.

We also permit an optional adjustment for increases in wages of nonsupervisory employees. Wages have not been the driving force in hospital costs increases. Historic trends in hourly increases have been 7.2 percent for hospital nonsupervisory workers for the past six years. Even assuming that these wages should increase at a rate of 9.5 percent, the allowable revenue limit would be increased by less than a percentage point. This provision is important to protect low-wage hospital workers from any adverse impact of cost constraints.

You also expressed some reservation about our program's differential impact on efficient and inefficient hospitals.

We do not believe our program penalizes efficient hospitals. Efficient low-cost hospitals should not need increases greater than 9 percent. It is true, however, that our program does not eliminate all of the waste and inefficiency in the system. As I indicated earlier, one of the major technical deterrents to doing so is the lack of an adequate classification system for distinguishing efficient and inefficient hospitals. But our plan would penalize those inefficient hospitals whose costs are currently rising at a greater than 9 percent rate, and put us in much better position to ferret out remaining inefficiency in a long-term solution along the lines you have proposed.

Furthermore, the Administration proposal does build in a number of rewards for hospitals which choose to become more efficient:

Hospitals that close unnecessary facilities or eliminate duplicative equipment would have revenues for these services retained in the base (if the HSA approved discontinuance of these services). Thus, the hospital would be permitted a greater than 9 percent increase on remaining services.

Hospitals that work with their medical staffs to eliminate unnecessary tests, admissions, or days of stay would be permitted higher allowable revenue per unit of service—since our limit is on total revenue increases.

Mr. Chairman, you also indicated some concern about starting with a transitional cost containment program and then moving to a longer-term system. As noted, we feel strongly that the problem of rising costs is of such disastrous pro-

portions that we simply cannot wait for a perfect solution before acting. It is important, however, to provide for an orderly evolution. We have designed our transitional program so that it will be compatible with a number of more fundamental structural reforms of reimbursement methods, including the type of incentives for improved efficiency contained in your bill.

Finally, I would like to respond to one other query about the administration's program—namely, that any slowing of the rate of increase in hospital costs can only be achieved by lowering the quality of patient care.

Mr. Chairman, your Subcommittee has contributed significantly to our understanding that more is not always better in the health care system. Unnecessary medication, hospitalization, testing, and surgery can be positively harmful to health and can constitute poor health care policy. Our program provides a strong economic incentive for hospitals to work with Professional Standards Review Organizations to curtail this unnecessary utilization. Unlike the current cost reimbursement system, our program would reward the hospital which chooses to reduce the length of patient stay or reduce unnecessary admissions.

Both Title I and Title II of our plan would provide strong incentives for hospitals to reduce unnecessary specialized facilities. For example, studies have shown that to maintain minimum standards of quality, a cardiac center should perform four to six cardiac operations weekly. Over 80 percent of all hospitals performing cardiac surgical procedures do not meet this requirement. In fact, an independent study of a Massachusetts hospital were 49% of open-heart surgery patients died during the period 1968–1975—an unusually high death rate—concluded that an inadequate number of open-heart operations at the hospital, and the resultant inexperience of the cardiovascular team, contributed to the poor results. The Administration's proposal can help eliminate underutilized cardiac care facilities, promote regionalization, and thus improve patient care.

Another area where substantial cost savings would be achieved with an actual improvement in quality of patient care is inhalation therapy. Mr. Chairman, your staff has alerted the nation to alarming improper professional practices in this area. One study indicates that approximately \$500 million could be saved by eliminating those inhalation therapy procedures which are of dubious benefit.

In sum, with the help of this Subcommittee, we have identified over \$5 billion in savings that can be achieved without harming patient care. A "fat list" of those wasteful or unnecessary items which could be trimmed back without affecting quality of care is appended to my statement.

For these, and for other reasons that I will hopefully detail before this Subcommittee when it considers the Hospital Cost Containment Act of 1977, we believe that the Administration proposal is a necessary precursor to the major, structural hospital reimbursement reforms set forth in S. 1470.

HOSPITAL CAPITAL CONSTRAINTS

The legislation you have introduced also contains important provisions for dealing with the problem of over-capitalization in the hospital industry. The Subcommittee's concern with elimination of unnecessary hospital beds, as reflected in Section 3 of S. 1470, and with strengthening sanction against institutions which provide services with unapproved capital facilities or equipment, as reflected in Section 4, is shared by the Administration.

In the Hospital Cost Containment Act of 1977, we have addressed these concerns in a slightly different fashion. We, too, are convinced that it is important to restrict Medicare, Medicaid, and Maternal and Child Health payments not only for the depreciation expenses of unapproved capital expenditures, but also for their associated operating expenses. Besides limiting the dollar amount of certificates of need that can be issued within each State, the provisions of our bill would use a ratio of \$10 of operating expenses for every \$1 of depreciation expenses in estimating the relevant operating expenses to be disallowed.

We would also encourage the closing, modification, or conversion of underutilized hospital beds by several methods. The Administration proposal permits hospitals to retain any discontinued beds, services, or facilities approved by the HSA in their revenue base. It also prohibits net additional bed investment in areas which are already overbedded.

I hope my staff can explore with yours the most effective and appropriate methods of eliminating unnecessary hospital capacity.

OTHER PROVISIONS

As I have indicated, Mr. Chairman, the Administration in less than half a year has followed the lead of this Subcommittee in a number of areas. We have focused on the problems that seemed most urgent.

But the Medicare-Medicaid Administrative and Reimbursement Reform Act also has identified a number of other problems that beset our present health care system. These problems are correctly identified, and many of them, such as devising criteria for determining reasonable charges for physician's services, are matters of great concern to the Administration, and to the American people.

Given our emphasis on what we believed were the most pressing problems, my staff has not yet fully analyzed all other major provisions of the proposed legislation. The general thrust of those reforms seems correct.

The health team at HEW is considering many proposals that are similar to the ones set forth in your bill, and we will continue to work at full speed to evaluate the many complex factors that underlie some of the more far-reaching reforms advanced in S. 1470.

We look forward to the informative record that this Subcommittee will develop on these issues in the weeks ahead. I also look forward personally to a long and productive relationship with you and your staff. We in the Executive Branch have much to learn from your path-breaking efforts.

Thank you very much.

APPENDIX TO STATEMENT OF SECRETARY JOSEPH A. CALIFANO, JR.

HEW has identified over \$5.0 billion savings which could be achieved by hospitals without harming patient care:

First, according to the American Hospital Association's own data, community hospitals accumulated \$1 billion in profits (or surplus revenues) that were put into hospital cash reserves in 1976. Nearly all of the reduced revenues which we are requesting could come from cutting out these surpluses for this largely nonprofit hospital industry.

Second, there are today about 240,000 empty beds in our community hospitals. At least 100,000 of these beds are absolutely unnecessary.

At a maintenance cost of \$10,000 to \$20,000 per empty bed, the annual cost of 100.00 empty beds is \$1 billion to \$2 billion.

Yet, in 1976, 27,000 additional beds were built in the United States at a construction cost of \$2 billion.

The Hospital Cost Containment Act of 1977 would prohibit additional hospital beds in areas that already have more than 4.0 beds per 1,000 population—the standard endorsed by the Institute of Medicine. As a positive incentive, a hospital closing beds with the approval of state and local planning bodies would be permitted to retain the allowable costs from those beds in its revenue base.

Third, there are now 700,000 people in the nation's acute-care hospitals. As many as 100,000 of them—almost 15 percent—do not need to be hospitalized and would be better cared for at home, in skilled nursing facilities, or on an outpatient basis. These patients are generating excess charges of \$7 million per day just for operating costs, or \$2.6 billion per year.

Since the limit in the Administration's cost containment bill is on total revenues, a reduction in unnecessary admissions will automatically permit the hospital a higher rate of increase in allowable revenues per patient. Thus hospitals would have an incentive to work with their medical staffs to reduce unnecessary hospital admissions.

Changing these economic incentives to the hospital should help existing utilization review and PSRO programs work more effectively.

Fourth, the Institute of Medicine released a study recently that strongly urged careful controls on the purchase and use of CT ("CAT") scanners, a sophisticated x-ray and computer diagnostic tool costing one-half million dollars or more. Currently, there are approximately 500 scanners in the United States with a total operating cost of \$150 million to \$250 million annually. At the rate that the scanners are being adopted, the bill for scanning could quadruple in just the next three years, with little noticeable change in the care of the American citizen.

The Administration proposal would slow the purchase of redundant equipment by limiting new capital expenditures to about one-half the projected increases for new capital equipment and modernization.

Fifth, hospitals have not carefully examined their use of energy. A recent HEW study found that hospitals could reduce energy costs by up to 20 percent in the first year by reducing high water temperature, recycling air, improving insulation, monitoring heating plant efficiency, and cutting use of nonessential equipment during peak hours. These measures would have saved \$332 million if in place last year and could save nearly one-half billion dollars by 1980.

The Administration proposal would give hospitals an economic incentive to institute energy-saving measures—most of which can be achieved without major capital expenditures.

Sixth, use of expensive and often unnecessary therapies has increased rapidly in recent years. For example, individual hospitals report that as many as 25 to 30 percent of patients receive inhalation therapy services. Estimated costs are \$500 million annually. Yet there is limited professional evidence to support the widespread use of such procedures.

The Administration proposal would encourage hospital administrators to work with their medical staffs to eliminate unnecessary services and tests. Allowable revenues from these services and tests would remain in the base. Since the limit is on increases in total revenues, hospitals would be permitted greater than 9 percent increases on other services to the extent that these tests are curtailed.

Finally, hospital costs would be cut substantially by not admitting patients several days before treatment, as is often done now. Pre-admission diagnostic tests should be conducted on an outpatient basis. Friday and Saturday admissions should be eliminated if laboratory and operating facilities are closed on weekends.

The Administration proposal would give hospitals an incentive to reduce lengths of hospital stays. Any reduction in stays results in an automatic increase in the allowable revenue increase on a per diem basis. Again, these changed economic incentives should strengthen our existing utilization review programs.

[A brief recess was taken.]

Senator TALMADGE. The subcommittee will come to order.

The next witness is Hon. David Hollister, Representative of the State of Michigan, on behalf of the National Conference of State Legislatures.

Mr. Hollister, we are delighted to have you with us. We have many witnesses and the Senate is in session. If you desire to do so, you may insert your statement in full in the record and summarize it.

STATEMENT OF HON. DAVID HOLLISTER, REPRESENTATIVE, STATE OF MICHIGAN, ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

Mr. HOLLISTER. It will be a pleasure, Senator. I will respectfully do that.

I will try to highlight the aspects of my testimony. One aspect relates to what States are doing now in cost containment areas, specifically where we as State legislators agree with provisions of the Senate bill we are considering this morning.

Another aspect involves some suggested changes, or things to keep in mind for the record.

My background, Senator, is as a second-term legislator in the Michigan House, where I have chaired the mental health committee. The speaker has appointed me to his special committee on welfare reform and his committee to investigate welfare fraud.

I am also representing the National Conference of State Legislatures.

States are very much concerned with the runaway health care costs. A decade ago, the medicaid bill was \$1.6 billion a year. It is projected

for next year, 1978, to be \$18 billion. That has had a devastating impact on State budgets across this country.

The States' response has been multiple. One response has been to reduce the scope of services available to citizens, the second response is to reduce the number of individuals who are able to be served. Another response is to increase patient cost-sharing requirements.

Another response is to eliminate the service coverage, a response that Michigan has recently enacted. The States are groping for ways to contain costs, and they are experimenting.

In 1970, New Jersey developed a computer data system which became the model for the HEW medicaid management system and using that, it has saved \$27 million.

Eleven States have now incorporated the medicaid management information system. Twenty other States are moving in that direction.

Connecticut created a commission on hospital and health care with decisionmaking authority over capital expenditures, annual operating budget reviewing rights, and analyzing costs.

Six other States are operating with mandatory ratesetting systems.

California issued a medicaid card outlining the services available to an individual. Any services beyond that must be approved by a team of doctors.

In Michigan, we have initiated several cost-saving procedures. Michigan was hard hit by the automobile recession. As you know, we are heavily dependent on the automobile industry. We had a high unemployment rate and increased welfare costs—costs which increased health care costs and put a real crimp into our budget.

We just simply reduced payments to providers by 11 percent. We discounted their bills. We eliminated physical therapy in nursing homes. We put a 14-day limitation on inpatient psychiatric care. We eliminated dental, vision and hearing services for people over 21.

Those were drastic steps that we have had to take in the past to try to contain the costs. For this year, we are moving to a couple of other provisions. One, a prepayment review of hospital invoices for patients staying more than the 75th percentile of hospital stays. We initiated programs through legislation, recovering costs on third party liability, making Medicaid a payee of last resort, not first resort.

Finally, we are initiating the generic drug law in Michigan.

Even with these savings, 1 out of every 4 new dollars will go to the medicaid budget in the State of Michigan.

With that background, we applaud you and the committee for Senate bill 3205 of last year and Senate bill 1470 of this year. We also thank Mr. Constantine for his openness and sincerity and willingness to listen to the suggestions that the State legislatures have had in the past, and which have been incorporated into the changes which you highlighted in your statement earlier.

Our position has been developed through our human resource committee, with representatives from all the State legislatures and the health and welfare committees. In addition the State Federal Assembly of the NCSL has unanimously endorsed the concept of your bill and the highlights of my testimony this morning.

Specifically, we enthusiastically support certain provisions of the Senate bill. First, the exception of states with effective rate-setting

systems from the bill's hospital reimbursement provisions, we think, makes good sense.

In your opening statement this morning you indicated a willingness to expand your bill and widen its context to include more than just medicaid and medicare. We feel this ought to be done. We believe that the legislation ought to apply to Blue Cross, Blue Shield, and other private payees.

Another point to keep in mind is that cost containment is still an art, not a science and flexibility and experimentation should be encouraged. To designate one approach is too rigid and could be inequitable and doomed to failure.

All States should be required to meet Federal minimum standards with incentives for doing better, and I think your bill moves in that direction. We should require a good data base collection from the Department of Health, Education, and Welfare, working with State and local agencies in developing evaluation techniques.

We enthusiastically support the provision for technical assistance to the States for improving management administration and operation of the program.

We enthusiastically support the requirement that regulations pertaining to this act be issued in 13 months.

In developing those regulations, we have some things that we think ought to be kept in mind. One, that HEW should consult with State and local officials and the results, as they are developed, should be issued in advance, with a clear explanation of purpose and objectives.

We also like the President's recommendation that the Secretary read the provisions and understand them himself.

We feel, in developing HEW regulations, that State variations should be allowed. We think, Senator, in mandating requirements, priorities should be established.

Although we want to comply with regulations all the way, sometimes that is not possible.

We think reasonable deadlines ought to be established and agreed upon by State and local officials and we specifically feel that there should be an update of present requirements and simplification of present medicaid regulations.

We applaud and enthusiastically support the provision which dictates that information concerning the inefficiencies of the program be made available not only to the Governor, but shared with the legislative leadership and the appropriate legislative committees.

We are always the last to know. Like the poor husband, he finds out last when things have gone astray, and we in the State legislature are also frequently the last to find out about a program that has failed. We applaud the effort to include legislative leadership and committee leadership in this effort.

This is unprecedented in Federal legislation and welcomed by the state legislators with enthusiasm.

We also endorse the provisions for strengthening medicaid administration. We do have a few concerns that I would like to share with you, and then answer any questions that you might have.

Our major concern is that performance standards are dependent upon the MMIS program being in place and not all States have that

in place and we need to think about phasing that in. There is also a question of paying for that MMIS program, and whether or not the present matching ratio ought to be increased.

We have a concern that the medicaid requirements are very detailed and specific. We question whether they should be locked into statutory language.

We have a concern that some States already meet or exceed performance standards while others are just beginning. How do we bring those others up without holding the ones that have moved ahead behind. And moving the other States up is going to be a considerable cost to States which have not done this job.

How do we meet their needs?

We are concerned about the 75th percentile quality control rate as being rigid and arbitrary.

We specifically would like to share our concern with you about the fiscal penalty, and feel that incentives ought to be built in and not necessarily limitations.

We think that there ought to be periodic corrective action plans and then, and only if the States refuse or are unable to meet the action plans, then apply the penalty. Do not apply the penalty immediately.

Performance standards should be a vehicle for ongoing assessment, not a vehicle for fiscal penalties. We should distinguish between willful intent not to comply, which should have penalties, and inefficiency, which should have technical assistance. This, the bill ought to recognize. There should be positive incentives of higher matching ratios to encourage good programs. Again, we feel that HEW should develop the data; HEW should be able to reimburse up to 90 percent of the administrative costs of programs that are doing a good job and meeting the high standards that we all look forward to. And we think MMIS should be a top priority in every State and should be reimbursed on a 75 to 25 percent basis.

Senator, in summary, the State legislatures are enthusiastic about most of your proposal. We are hamstrung with increased cost in medicaid, and we desperately want to see some kind of action. We see this as an excellent vehicle to do that, and with our limited concerns, we enthusiastically endorse the proposal before this committee.

Senator TALMADGE. Thank you very much, Mr. Hollister, for a very fine statement.

I understand the National Conference of State Legislatures has been very helpful in helping us to draft this bill. We greatly appreciate that.

Virtually every State government in the United States has had great difficulty with their medicaid payments.

I know that is true in Georgia and is one of Governor Busby's principal problems. If you have any further recommendations to improve the bill, we would appreciate you submitting them in writing to the staff.

Thank you very much.

Mr. HOLLISTER. Thank you.

[The prepared statement of Mr. Hollister follows:]

STATEMENT OF REPRESENTATIVE DAVID C. HOLLISTER ON BEHALF OF THE NATIONAL
CONFERENCE OF STATE LEGISLATURES

My name is David C. Hollister and I am a state representative from Michigan. I have served in the Michigan state legislature for the past three years, during

which time I have been the Vice-Chairman of the House Committee on Public Health and Social Services and as Chairman of the House Committee on Mental Health.

I have also served as a member of several committees relating to social services and health care, including a special committee to rewrite Michigan's social welfare law and investigate medicaid fraud.

My office has also initiated several citizen's task forces, including a welfare reform task force and a medicaid review task force. Both these task forces have worked with the department of social services in identifying program areas in policy and service delivery as well as with legislative committees to address these problems through legislation.

Also, as a state legislator I am a member of the National Conference of State Legislatures and it is on behalf of the NCSL that I appear before you today. For your information, the NCSL is the only National organization representing the interests of the nation's 7,600 state law makers.

I am delighted, Mr. Chairman, to appear before you and the members of this committee.

STATE LEGISLATIVE INTERESTS

I need not tell you that the unacceptable growth in Medicaid expenditures over the past few years is undoubtedly one of the most troublesome problems facing all levels of government today. You will recall that in its first year of operation a decade ago, state and local governments, along with the federal government, spent \$1.6 billion on the medicaid program. Projections for fiscal year 1978 estimate the cost of the program at nearly \$18 billion—an eleven fold increase that has all levels of government searching for ways to bring the expenditures back within acceptable bounds. Needless to say, such cost escalations have had a tremendous impact on state budgets. Medicaid expenditures are already assuming a disproportionate share of the limited state funds available to finance social programs for low income individuals. As you so correctly noted last year in your introduction of S. 3205, Mr. Chairman: "the choice is a simple one—either we make medicare and medicaid more efficient and economical or we reduce benefits."

While the factors contributing to the rapid expansion in the costs of providing medicaid services are easily discernible—inflation in medicaid prices and fees, expansion in the number of eligibles served, growth in the utilization per eligible person—effective and equitable methods for controlling the acceleration of costs are more elusive.

In the face of growing budgetary restraints, the most common response by the states has been to focus on reducing either the scope of services offered or the number of individuals served under the program. Other short term steps taken to reduce costs would include such actions as increasing patient cost-sharing requirements for basic and optional services and lowering the reimbursement fee levels for ambulatory services. Random examples of the above include: The elimination of adult dental services from coverage by Maryland, Florida, Georgia, New Hampshire, and Louisiana; the institution of a co-payment for eyeglasses in Virginia and Michigan, and the restriction of one physician visit per month in Alabama and Georgia.

Increasing recognition however, is being given to the contribution poor management and administration of the medicaid program makes to the problems of costs.

Waste and mismanagement is likely to continue unless the conduct of the administration is appropriately checked. This is the duty and the function of the state legislature. In addition to its policy and program development role, the responsibility of the legislature extends to the control of policy and program after the stage of formulation. The legislature must review the performance of its administrators—conducting oversight, curbing dishonesty and waste, ensuring compliance with legislative intent, and challenging bureaucrats. It must also assess the effectiveness of state policies and programs.

Currently in addressing the problem of rising medicaid costs state legislatures have basically three options: Continue to appropriate money to the program at increasing rates; cut benefits and reimbursements; or effect savings within the program itself. The later option implies getting a better handle on managing and administering the program.

As you are aware, some of the most effective and innovative measures in containing health costs have been introduced through state medicaid programs.

Most of the attention so far, however, has been on curbing fraud and abuse in the program. For example, during 1970, New Jersey developed a computer system to detect patterns of fraudulent practice and abuse. The ingredients of that system were adopted by HEW in developing the Federal medicaid management information system (MMIS). New Jersey's system resulted in a \$27 million saving just by prescreening claims. Additional savings were incurred through an aggressive investigation and prosecution of several nursing home operators, pharmacists and doctors.

Over the past few years—in cooperation with and encouraged by HEW—many state legislatures have sought to aid the medicaid management process by expending large amounts of state funds for the development of MMIS systems. MMIS, including the surveillance and utilization review components, is directed specifically at controlling utilization, cost effectiveness and maintenance of quality care. These systems give medicaid program directors and state legislators a state wide perspective on how the medicaid program is being used or abused. Eleven states now have a certified MMIS system; an additional 20 states are in the process of implementing MMIS this year.

States retain the authority to determine rates and methods of reimbursement. Although somewhat constrained by Federal statute and regulations, states have developed a variety of policies in this area. Through the budget process, state legislatures have dictated reimbursement policy to a certain extent. A few states have developed sophisticated reimbursement policies, each tailored to a specific provider program. Some states have experimented with regulating the medical care industry, on the assumption that controlling costs only in one part of the health care sector will only result in a "ballooning out" effect in other areas of the sector. As an example, in 1973 Connecticut created a commission on hospitals and health care, with decisionmaking authority over capital expenditures and annual operating budgets, as well as reviewing rates and analyzing costs. As a result, in its first year of operation the CIHC reported that the percentage of increase in cost per adjusted patient day was 8.4 percent, compared to 10.9 percent nationally. Presently, six states are operating mandatory rate setting systems with several other states sponsoring a rate review methodology of one sort or another.

Since 1970, several states have supported experiments with the delivery of services to medicaid recipients through prepayment plans. The experiences of CIHC programs in Washington, Kansas, Kentucky, Michigan, New Jersey, and the District of Columbia are worth studying.

The state of California instituted several methods to reduce overutilization. Each recipient's medical card indicates the services the recipient is entitled to. Additional services sought by the recipient beyond those mentioned on the card must be approved by a medical field office before payment can be made. Moreover, a new program implemented at the end of 1975 requires every hospital serving medicaid patients to include a team composed of a physician, a nurse and a social worker. The team, in cooperation with the attending physician, must make a determination regarding the recipient's length of hospital stay. Preliminary results indicate that the average length of hospital stay has been reduced.

The state legislature in Wisconsin established a 30 member strike force against medicaid fraud. Investigation and audits carried out by the Illinois bureau of special investigation and the Governor's task force on medicaid fraud resulted in the suspension of 60 medicaid providers. Illinois has also reduced costs by changing the formula for reimbursing pharmacists for medicaid prescriptions. In New York State, audits of the nursing home industry are expected to help return almost \$70 million in overcharges to the state's treasury. Last year Minnesota began a pilot project of restricting recipients' use of physician and pharmacy services in cases where there is documented evidence or abuse or misutilization of these services.

Michigan probably has a greater degree of experience with medicaid cost containment efforts than any other state. Recent periods of high unemployment have increased the state's welfare rolls and have concurrently reduced state revenues. This combination, with that of rampant health care cost inflation, has meant that medicaid has had a devastating effect on our state's budget.

In December of 1975 the Governor issued an executive order containing a number of medicaid reductions. Because of the immediacy of the state's fiscal plight, we could not sufficiently assess the ramifications of the measures taken. Some of the programmatic changes included:

An 11 percent reduction in payment rate for many medicaid providers;
 Elimination of physical therapy coverage in nursing homes;
 A 14-day limitation on inpatient psychiatric services; and
 A reduction of the protected income level for medicaid only recipients, and the
 termination of dental, vision and hearing services for persons over 21.
 Most of these measures have long since been abandoned or modified because
 they either were not effective cost savings devices or had a devastating impact
 on clients.

As the legislature considered the current fiscal year's appropriation for medic-
 aid it became apparent that available state funds for this program were sig-
 nificantly lower than projected expenditures. The Governor and legislative
 leadership joined together in a meeting with representatives of all major pro-
 fessional associations to outline the dilemma and to seek their help in developing
 and implementing effective and appropriate cost containment measures for the
 medicaid program. That effort was successful and resulted in a number of posi-
 tive policies such as:

Prepayment review of hospital invoices for patients staying beyond the 75 per-
 cent length of stay for that diagnosis;

Increased efforts by providers to identify and bill other third party sources;

The establishment of a generic drug policy and revisions in the adult dental
 and vision program.

Although these efforts were largely successful, I would like to note that the
 Governor's statewide budget for fiscal year 1977-78 allocates one out of every
 four new state dollars to medicaid. This despite inclusion of substantial savings
 effected as a result of the cost containment initiatives.

In summary, despite the fact that we in Michigan have made significant efforts
 to identify and implement appropriate cost containment measures, it is abun-
 dantly clear that these efforts in medicaid alone cannot resolve the fundamental
 problem at hand—one of uncontrolled health care cost escalation. The need is
 great, therefore, for an effort at the Federal level which can effectively en-
 courage the application of proven cost containment measures and sound manage-
 ment procedures by all levels of government and by the entire medical care
 industry. We believe that the Talmadge bill is a major step in the direction of
 achieving those goals.

* * * * *

S. 1470

Mr. Chairman, we at the state level realize the enormous time and energy
 that was devoted to the creation of this legislation. Moreover, we sincerely appre-
 ciate the willingness—and even the initiative—taken by your staff to meet with
 representatives of state government on the merits of this bill. Over the past year,
 our very able staff director, Mr. Constantine, has conferred with members of
 your organization on several occasions and, at each meeting, made it clear that
 the contributions of state officials are most highly valued by the committee. We
 have taken this invitation most seriously, Mr. Chairman. In preparation for
 his testimony we have gone through a series of steps to ensure a broad range
 of inputs from elected officials and program administrators at the state level.

The recommendations which follow were originally submitted by the Human
 Resources Committee of the NCSL. That committee is comprised of chairmen and
 ranking members of health and welfare committees from practically every state
 legislature. Those recommendations were then considered by our State-Federal
 Assembly (SFA) and were adopted unanimously. The SFA includes over 400
 state legislators, representing every state and both political parties, and has
 the exclusive authority to speak on behalf of the organization with respect to
 issues affecting State-Federal relations.

In general, Mr. Chairman, state legislators are enthusiastic about this bill.
 Reasonable attempts to fulfill the many objectives stated in S. 1470 deserve the
 attention and support of all levels of government. Those objectives specifically
 relate to addressing several problem areas in the medicaid and medicare pro-
 grams. Those problem areas include:

The lack of uniform and efficient program management and administration;
 Excessive and steadily rising costs in medicare and medicaid;
 Ineffective enforcement of regulations by HEW; and

Inefficient cost-generating reimbursement policies of hospitals, nursing homes, and to some extent, physicians.

Several provisions within S. 1470, if implemented, offer an excellent chance of resolving many of the aforementioned problems. NCSL specifically supports the following key measures:

I. EXEMPTION OF STATES WITH EFFECTIVE RATE SETTING SYSTEMS FROM THE BILL'S HOSPITAL REIMBURSEMENT PROVISIONS

Rising hospital costs have been a major concern to most states for a number of years, and several of the third-party payers—particularly medicaid and Blue Cross/Blue Shield—have initiated programs which aim at restraining hospital costs. However, what that experience confirms is that policies promoted by different payers acting alone can have only a limited impact on controlling hospital costs for the whole system. If the reimbursement system is to provide the lever for controlling costs, a uniform policy which applies to all hospital payers is highly desirable. The approach contained in S. 1470 constitutes a major improvement over the current hospital reimbursement structure but should extend even further to reach all payers.

The present piecemeal reimbursement structure is an inequitable and ineffective approach to hospital cost containment, as well as being a disruptive influence on hospital planning and financing. Reforms which apply to the reimbursement policies of only a single payer (e.g., medicaid) provide strong incentives for hospitals which are being squeezed by that payer's policies to either opt out of the program or to pass on the costs to other purchasers. In such circumstances costs are shifted from payers who have imposed reimbursement constraints (e.g. medicaid) to other payers who do not or cannot control their level of reimbursement (e.g., private insurers and patients without insurance). The result is that total hospital costs are not effectively controlled, private payers realize an inequitable fiscal burden, and those hospitals which have a high proportion of medicaid patients bear the brunt of cost containment efforts. Furthermore, hospitals may increasingly view medicaid admissions as undesirable, with the long-run result that medicaid admissions are shifted to a few hospitals. Since those hospitals would then face increasingly tighter cost constraints relative to other hospitals, the result might very well be a discernably different hospital delivery system for medicaid patients.

There is no dispute that a sensible hospital cost control system must precede the implementation of a national health insurance program. Substantial disagreement may exist, however, over what kind of cost control system will prove effective and what level of government should be responsible for administering and operating the system.

Given the fact that cost containment is still largely an art, not a science, flexibility and experimentation should be key to the eventual discovery of a system or systems that will function properly. The assumption that the solution to cost inflation in the hospital sector lies in a single approach is a faulty one and, if allowed to guide our policy, is likely to lead us into a system of extreme rigidity and inequity.

Hence, we believe, as the bill suggests, that states operating rate review programs which either meet or exceed minimum Federal guidelines should be free to continue to administer their own hospital reimbursement programs. The use of state expertise and staff would greatly augment the limited number of Federal employees who would be available to administer a nationwide program.

We wish to emphasize, however, that the criteria by which states would be permitted to operate their own hospital reimbursement systems should be minimum standards. Since the development of a sound incentive system for reimbursing hospitals is still in its infancy, states should not be put in the position of having to demonstrate "beyond a reasonable doubt" they can do a better job than the Federal Government.

The legislation should encourage further state experimentation with alternative hospital reimbursement mechanisms in order to build an information and data base necessary to examine and resolve several critical issues prior to the establishment of a national health insurance system. Strong evaluation measures should be built into the program to insure that innovations in technology and procedure are measured, preserved and made available nationwide.

Additionally, the legislation should contain incentives to states to adopt even tougher standards than federal requirements. For example, if a state operated system can manage to control hospital costs below a reasonable level, the state

should be able to retain part of those savings and devote them to such purposes as preventive services and debt retirement on unnecessary facilities.

I. PROVISION OF TECHNICAL ASSISTANCE TO THE STATES FOR IMPROVING THE MANAGEMENT, ADMINISTRATION AND OPERATION OF THE PROGRAM

On numerous occasions states have sought technical guidance from the federal and regional offices, only to be ignored or refused because the necessary technical expertise was unavailable, given the increased number and complexity of federal statutes and regulations, as well as performance standards expected under the proposal, improved technical assistance is indispensable to the ultimate effectiveness of this legislation. We are, nevertheless, concerned that while the bill calls for increased technical assistance, no recommendation appears calling for additional federal dollars to be allocated for that purpose. Moreover, we would like to be assured that if the resources are available, they not be consumed by monitoring and enforcement functions to the detriment of needed technical assistance services.

II. REQUIREMENT THAT REGULATIONS PERTAINING TO THIS ACT MUST BE ISSUED BY THE SECRETARY OF HEW WITHIN 13 MONTHS OF PASSAGE

The record of the department over the past few years in issuing timely regulations has been extremely poor. On several occasions states have been plagued with complying with requirements which become effective before final regulations are published and under which their compliance will ultimately be evaluated. One concern, however, is that the need for expedition not infringe on the need for greater clarity in the regulations. NCSL offers the following specific suggestions with respect to medicaid regulations:

Consultation with representatives of state and local governments should precede the development of medicaid regulations. The regulations should be issued well in advance of the effective dates and the purpose and objectives of the regulations should be clearly specified.

State variations should be allowed in implementing the regulations, recognizing the differences in relative wealth and poverty and other socioeconomic factors. Criteria should be developed in light of these variations. Standards by which to evaluate state compliance with regulations must be formulated, with an emphasis on outcome objectives rather than process measure or technical requirements.

In view of the fact state and local governments are confronted with several sets of regulations at the same time, DHEW should, in consultation with the units of government affected by the rules, establish some priorities among the mandated requirements.

Reasonable deadlines for compliance with regulations should be agreed upon by all levels of government affected by the regulations.

An updated and simplified compilation of Medicaid regulations is badly needed. The task should begin with the following regulations specified in order of importance:

1. Financial eligibility requirements.
2. Hospital reimbursement.
3. Nursing home standards, including quality of care.
4. Cost sharing.
5. Freedom of choice.
6. Single state agency.
7. Regulations preventing states from eliminating or restricting dual certification of ICFs and SNFs.

III. REQUIREMENT THAT INFORMATION REGARDING DEFICIENCIES IN THE ADMINISTRATION OF A STATE'S MEDICAID PROGRAM BE MADE AVAILABLE NOT ONLY TO THE GOVERNOR OF THE STATE, BUT ALSO BE SHARED WITH THE LEGISLATIVE LEADER OF EACH HOUSE IN THE STATE LEGISLATURE, AS WELL AS THE CHAIRMAN OF THE LEGISLATIVE COMMITTEES WITH JURISDICTION OVER THE MEDICAID PROGRAM

Mr. Chairman, it is an unfortunate reality that legislators are often among the last to know when things are going wrong with the medicaid program. The deference S. 1470 pays to the importance of the State legislative branch government—in recognizing its accountability for the expenditure of state

funds and assuring program effectiveness—is unprecedented in federal legislation and welcomed with great enthusiasm. This provision will unquestionably strengthen the legislatures' ability to oversee the administration of their Medicaid program. Moreover, it should spur greater interest on the part of the appropriate committees to continually evaluate the performance of their own state agencies.

V. PROVISIONS FOR IMPROVING MEDICAID ADMINISTRATION

S. 1470 calls for specific reforms in the administration of Medicaid by establishing specific performance standards in four areas:

1. Eligibility determination;
2. Quality control;
3. Claims processing; and
4. Program reports and statistics.

While the introduction of performance standards represents an appropriate step towards improving program administration and management, NCSL feels the following specific concerns must be accommodated:

1. Since compliance with the performance standards in the four broad areas is largely dependent on the assistance of fully operating management information systems, state and local governments will need more lead time than the proposed October 1978 effective date offers. Additionally, we recommend that the federal government assume the full cost of the development and operation of these management information systems.

2. The Medicaid requirements are extremely detailed and specific. The advisability of locking such regulatory language into a statute is seriously questioned.

3. While several states already meet or exceed the performance standards in the bill, many other states will be unable to comply without a substantial increment in state expenditures.

4. The standards related to the area of quality control give us considerable difficulty. To begin with, a maximum error rate for eligibility determination set at the 75th percentile of rates reported by the states (between a specified time period) will always be an arbitrary standard. More equitable measures which recognize state capacities could be developed, rather than legislating such a rigid statistical requirement.

5. Even more troublesome is the tying of a fiscal penalty to certain tolerance levels. Given the fact that "quality control" is still an art and not a precise science—that is to say no one has the answer as to what combination of factors will guarantee a reduction in errors—we find the attachment of fiscal penalties to tolerance levels unacceptable. Instead, we would prefer to see a nationwide quality control system developed as a management tool which will allow elected officials, program managers and the public to reliably and validly know the accuracy of the eligibility system at regularly recurring intervals.

The basic principles of this nationwide quality control system should be applied not only to medical assistance but to AFDC, SSI and food stamps as well. Additional administrative standards should not be mandated by the federal government without prior consultation with states and localities and until there is clear evidence of their cost effectiveness.

We further believe that no national performance tolerance levels should be established at this time. Instead, all states should be required to develop periodic corrective action plans, acceptable to the department of health, education and welfare, geared to the individual conditions of each state and including the state's specific targets for error reduction.

Sanctions, if necessary, should be applied only through the existing compliance procedure and only in those instances where a state clearly refuses to propose an acceptable corrective action or fails to appropriately implement the actions in the agreed upon plan.

We also recommend that the publicity of quality control findings should be continued with the following modifications:

More emphasis should be placed on publicizing in each jurisdiction the record of that single jurisdiction (national publicity makes it difficult for the public to evaluate the program which operates in their own localities.)

Public recognition should be given to those jurisdictions with low error rates or which are making significant improvements.

More emphasis should be placed on clarifying the causes of errors and the content of corrective actions plans.

In addition to the preceding recommendations NCSL offers the following suggestions for enhancing the quality and effectiveness of the administration and management of the medicaid program:

Performance standards should be viewed as an essential management or information device by which an ongoing assessment of the effectiveness and efficiency of a state's medicaid program can be made and by which areas of deficiency can be identified and corrected. Standards should not be used as a vehicle for the application of fiscal penalties.

With respect to the application of fiscal sanctions, efforts should be made to distinguish between willful intent not to comply and management inefficiencies. Where the latter is the problem, technical assistance should be the initial remedy with a specified time limit established for compliance.

The application of penalties should be only a measure of last resort. When program deficiencies are identified, a corrective action plan should be formulated by the state and technical assistance should be extended by DHEW to help implement the plan. Only when further review indicates non-compliance should a penalty be imposed.

Penalties should be levied on a flexible basis, in accordance with the degree of non-compliance.

Positive incentives, e.g., higher matching ratios, should exist to encourage worthwhile programs.

One of the serious deficiencies in medicaid management is the lack of comprehensive and comparable program information. DHEW should work with the states to establish a common set of data describing each state medicaid program, including information on reimbursement.

DHEW should have the authority to reimburse states up to 90 percent for administrative costs. In return for the increased match, states must fulfill certain performance criteria in the administration of the program. HEW would negotiate with each state on the conditions and standards that must be met in order to receive the higher match.

The development of MMIS within every state should be a major priority of DHEW. The matching ratios for development and operation of MMIS should be reconsidered in view of the disproportionate burden the costs have on predominantly low income states.

Staff to implement findings from the MMIS systems should be paid on a 75/25 percent matching basis.

The medicaid technical assistance role of the DHEW should be strengthened and upgraded and added emphasis should be placed on training federal staff on-site within the states.

DHEW—in cooperation with the major state and local public interest organizations—should foster inter-state technical assistance and resource exchanges for the improvement of medicaid management and administration.

In conclusion, Mr. Chairman, we suggest that while S. 1470 contains numerous worthwhile features that deserve widespread support, the bill should not be represented as the exclusive answer to controlling health care costs. Medicaid and medicare account for only one third of the total health care dollars spent nationally; therefore, the regulation of medicaid and medicare cannot control costs throughout the entire health care sector. Even if the bill's provisions succeed in holding medicaid and medicare hospital costs in line, there are too few safeguards to prohibit the reallocation of those costs to other third parties. Furthermore, we feel that action must begin right away on comprehensive health care cost containment. A delay until 1981 is likely to mean that hospital costs will have increased another 45 percent before we start to deal with them.

We believe that the development of a national health policy offers the most effective means of containing costs throughout the health care sector in the long run. Such a policy at a minimum would link decisions on provider reimbursement to effective health planning authorities. It would correct the present imbalance in the health care system between the emphasis on treatment of illness and the deemphasis on promotion of health. A national health policy can begin to grapple with some of the difficult public policy. Issues being forced on society by the proliferation of expensive, sophisticated technologies, such as, what kinds of health services shall be provided and where shall our limited resources be concentrated?

Last year in your introductory remarks on S. 3205 you indicated, Mr. Chairman, that the kinds of administrative and payment changes advocated in the

bill "are absolutely necessary prior to any expansion of the federal role in providing more health insurance to more people". You went on to suggest that absent these changes, "any expansion would be an open invitation to fiscal disaster".

While, of course, our presence here today is not to debate the merits or demerits of the various national health insurance proposals pending before Congress, we do anticipate that that debate may be forthcoming fairly soon and when the time comes, state and local governments will be anxious to make a contribution to a consensus as to the kind of health care system America ought to have.

In preparation for that possibility, state and local organizations have been working together over the past year to learn how their constituents felt about certain key issues in the national health insurance discussion, as well as to delineate what roles and authorities state and local governments ought to exercise under any new health care system. For the record, I would like to submit some attachments which describe in detail our concerns in this area, as well as some of the tentative recommendations we have developed.

Thank you once again for this opportunity to meet with you.

Senator TALMADGE. The next witness is Dr. Robert P. Whalen, commissioner of health, New York State, on behalf of the Association of State and Territorial Health Officials.

Dr. Whalen, we welcome you to the committee. You may submit your entire statement for the record, and summarize it.

STATEMENT OF DR. ROBERT P. WHALEN, COMMISSIONER OF HEALTH, NEW YORK STATE, ON BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

Dr. WHALEN. Thank you, Senator.

As the chief framer of this legislation, Mr. Chairman, you are to be congratulated for your foresight and perception. The ever-increasing costs of medicaid and medicare have indeed become an intolerable burden for Federal and State governments and for the Nation's taxpayers. We at the State level need relief from our burden and we need it now.

We note with interest and approval your recent comments that this bill does not compete with President Carter's Cost Containment Act, but instead, complements that legislation. We endorse the concept of adopting immediate interim restraints on health care costs while long-term solutions are worked out.

At or near the top of every State's priority list is relief from the current provisions of so-called reasonable costs in paying for hospital and long-term care. This misnamed and misguided policy has provided the Nation's health care industry with carte blanche to pass through to the governmental payer whatever costs the industry chooses to charge for its services. As a consequence, many States and local communities have reached the limits of their fiscal resources, even for such socially beneficial programs as medicaid.

When hospital rooms cost upward of \$300 a day, as they do in some metropolitan areas of our Nation, and when medicaid must reimburse some hospitals \$70 to \$80 a day for a single visit to a clinic or an emergency room, as was true earlier this year in New York City, I say to you that hospital costs are anything but reasonable.

Thus, our association strongly supports efforts to reform the administrative and reimbursement mechanisms in the medicare and medicaid programs. The bill before you represents a thoughtful ap-

proach to this urgently needed reform, and is a signal improvement over kindred legislation offered last year.

We wish to offer the following comments concerning the bill and some of its provisions.

Our principal concern is with the level of consultative and administrative control that this legislation would accord to the States, which together with localities, are legally responsible for the operation of the medicaid program and are expected to fund half of its costs.

Many States, New York among them, have been working for years to refine and implement effective programs aimed at controlling ever-rising hospital expenditures, and to do so without denying vital health services to those people who need them. These State programs represent a pluralism that should be encouraged to continue and progress.

This would not only give the Federal Government a benchmark against which to measure its programs of hospital cost containment, it would also permit these States to serve as laboratories for the development of innovative cost control procedures. We strongly recommend that States with existing and effective programs of hospital cost control be exempted from the hospital reimbursement provisions of this bill and that this waiver be granted without prejudice.

We endorse the concept of rewarding hospitals whose routine costs are below the average of their groups, and penalizing hospitals whose costs exceed the group's average.

But the classification of hospitals into groups differentiated only by bed capacity seems inflexible and unwieldy. More sensitive criteria may be needed to account for geographical differences, different sponsorship and variabilities in level of care that is provided. In New York State, for example, the character of the hospital industry in New York City is far different from that in rural areas upstate.

When New York State first sought to control hospital costs in 1970, we began by examining certain routine costs of inpatient care, as this bill does. Many years later and wiser, we have become more sophisticated in our efforts to contain hospital costs. We found that, when certain cost components are left out of a reimbursement formula, these costs often become artificially inflated in an effort to counteract restraints contained in the formula. Thus, when we placed stringent controls on reimbursement for inpatient care, we found that the average length of stay began to increase and that charges for outpatient and ancillary services shot upward at a precipitous rate.

Accordingly, we found it necessary to broaden our cost containment efforts to include ancillary costs, to set standards for average length of stay, and to place a ceiling on reimbursement for clinic and emergency room services.

I offer this experience as proof that cost control legislation, if it is to be effective, must cover ancillary as well as routine care.

This bill would allow hospitals to receive full reimbursement for costs up to 20 percent higher than the average of their peer group. In our view, this is far more permissive than the limit already set by some States. In New York State, for example, medicaid and Blue Cross reimbursement is limited to the average of the group. Those hospitals exceeding the average are penalized.

The concept of conversion allowance is, we believe, an ingenious answer to the problem of unneeded, underutilized hospital facilities. We believe such a provision would overcome the opposition many States have experienced when they have tried to close or consolidate unnecessary hospitals and hospital services.

Such efforts, however, should be closely linked to health planning at the State level, and should involve both health systems agencies and State health facilities planning agencies. Through this interface, the States would be in a position to identify those institutions and services that are redundant to need.

Many States have sought permission for hospitals to convert some beds to the level of nursing home beds, with appropriately reduced reimbursement. Heretofore, Federal health policy has not permitted this. Thus, we are pleased to endorse this provision in the bill.

And we also endorse the constraints placed on reimbursement of hospital-based physicians, such as anesthesiologists and pathologists, for services not directly related to patient care.

The performance criteria, reporting requirements, and penalties specified in relation to eligibility determination, claims processing, and data retrieval are, in our opinion, unrealistic.

In summary, may I say that we States, much like the Federal Government, need to coordinate our cost control efforts with related activities in health planning and development. The proposed legislation could be more supportive of such efforts by closely involving the States with the administration and intent of the legislation. For example, States could be asked to submit administrative programs that would integrate cost control, planning, and policy linkages at whatever level they might be currently operating.

In some States, this would be development of a strong capital expenditure control system, while in others it would be a coordinated and complex system of ratesetting, planning, and capital expenditures controls.

This could be at least partially accomplished through a State administrative program requirement. Such a requirement would need to be supported by federally established performance criteria tied to the intentions of the act, but in keeping with the unique situation of the various States.

Inherent in my testimony is the belief that something must be done immediately to cope with the explosive rise in State and local, as well as Federal Government, share in health care costs. But at the same time, we need a long-term approach, such as this bill, to the problem. We believe that considerable attention should be given to increasing State resources so that health care cost containment can be effectively planned, implemented, and evaluated.

I want to stress that ASTHO strongly endorses the intentions of this legislation. Our commentary is presented from the perspective of strengthening a useful and necessary proposal.

And if we may be permitted one final observation, it is that the increase in expenditures by the health care delivery system over the past decade has not demonstrably benefited the health status of the American people. We are confronted with rapidly increasing expenditures for new technology, more personnel, and new facilities, without a nec-

essary relationship to improved health. In addition to capping the costs of institutional care, we must consider increasing our investment in the prevention of illness and the promotion of good health practices on the part of the populace.

Senator TALMADGE. Dr. Whalen, thank you very much for an excellent statement. You are an expert in this field. Do you think this bill, as presently drafted, will do the job?

Dr. WHALEN. I think, Senator, that it is a very good beginning.

I think, as you move into this field, that approaching it by a grouping of hospitals and putting a ceiling on routine costs, making payments prospectively, and putting in an incentive payment, so those who are more efficient are rewarded, is a very good approach.

I think that eventually it is going to have to move, as you indicated in the bill, to ceilings in other areas of cost. This is a little bit more difficult. Groupings are more difficult as one moves to control ancillary costs, but I would heartily endorse the general approach of the bill.

Senator TALMADGE. If you or the Association of State and Territorial Health Officials have any further recommendations that might improve the bill, we would greatly appreciate your putting them in writing and submitting them to the staff.

Senator Dole?

Senator DOLE. I have just a couple of—more or less—comments.

In your statement, you indicate:

We strongly recommend that States with existing and effective programs of hospital cost control be exempted from the hospital reimbursement provision of this bill and that this waiver be granted without prejudice.

If I am correct, in the bill, if the Secretary is satisfied that a State hospital reimbursement system results in lower aggregate payments to hospitals in the State than the system established by the bill, then payments to hospitals in that State would be based on State system.

Dr. WHALEN. That satisfies our needs, Senator. I just wanted to make the point that the States heartily endorse that.

Senator DOLE. Then in that same general area, you talk about classifications of hospitals in groups differentiated only by bed capacity. I think also that the bill, as drafted, takes into account geographical differences and other areas of possible difference. It does have the flexibility that you suggest.

Dr. WHALEN. It does, Senator, when you are talking in terms of routine costs. I think over time, as one moves to a consideration of imposing ceilings on ancillary costs that the grouping process becomes much more difficult. One has to deal with such items as intensity of service, patient mix, and so on.

The only point that I was trying to make was that grouping of hospitals is not as simple as it might appear at first blush, and it is quite a complex undertaking and that there ought to be some flexibility in the bill that will allow for changes in groupings and changes in the criteria.

Senator DOLE. I share that view, and I am sure the chairman does. I believe the language is in the bill, but if it lacks flexibility, we can probably add it, but I think it may be there.

Thank you very much.

Senator TALMADGE. Thank you, Dr. Whalen. We appreciate your contribution.

[The prepared statement of Dr. Whalen follows:]

STATEMENT BY ROBERT P. WHALEN, M.D., IN BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

SUMMARY

The Association of State and Territorial Health Officials supports efforts to reform the administrative and reimbursement mechanisms in the Medicare and Medicaid programs. In particular, states need relief from the so-called "reasonable cost" provisions of the Medicaid program.

A principal recommendation of the Association is that states with effective programs of hospital cost control be encouraged to continue these efforts by exempting them from the reimbursement provisions of this bill.

The Association endorses the concept of rewarding hospitals with lower than average costs and penalizing those with higher than average costs.

Experience at the state level suggests that excepting ancillary costs from the reimbursement formula may weaken the effectiveness of cost control measures.

The concept of a conversion allowance is endorsed, as is the provision that would allow hospitals to convert some beds to nursing home level, with reduced reimbursement.

The Association believes cost control efforts at the federal level must be coordinated with activities of state health planning agencies.

Mister Chairman, Members of the Subcommittee, I am Dr. Robert P. Whalen, Commissioner of the New York State Department of Health, and I am here to testify on behalf of the Association of State and Territorial Health Officials, commonly referred to as ASTHO.

As the chief framer of this legislation, Mr. Chairman, you are to be congratulated for your foresight and perception. The ever-increasing costs of Medicaid and Medicare have indeed become an intolerable burden for federal and state governments, and for the nation's taxpayers. We at the state level need relief from our burden and we need it now.

We note with interest and approval your recent comments that this bill does not compete with President Carter's Cost Containment Act, but instead, complements that legislation. We endorse the concept of adopting immediate interim restraints on health care costs while long-term solutions are worked out.

At or near the top of every state's priority list is relief from the current provisions of so-called "reasonable costs" in paying for hospital and long-term care. This misnamed and misguided policy has provided the nation's health care industry with carte blanche to pass through to the governmental payor whatever costs the industry chooses to charge for its services. As a consequence, many states and local communities have reached the limits of their fiscal resources, even for such socially beneficial programs as Medicaid.

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Thus, our Association strongly supports efforts to reform the administrative and reimbursement mechanisms in the Medicare and Medicaid programs. The bill before you represents a thoughtful approach to this urgently needed reform, and is a signal improvement over kindred legislation offered last year. We wish to offer the following comments concerning the bill and some of its provisions.

Our principal concern is with the level of consultation and administrative control that this legislation would accord to the states, which together with localities, are legally responsible for the operation of the Medicaid program and are expected to fund half of its costs.

Many states, New York among them, have been working for years to refine and implement effective programs aimed at controlling ever-rising hospital expenditures, and to do so without denying vital health services to those people who need them. These state programs represent a pluralism that should be encouraged to continue and progress. This would not only give the federal government a benchmark against which to measure its program of hospital cost containment,

it would also permit these states to serve as laboratories for the development of innovative cost control procedures. We strongly recommend that states with existing and effective programs of hospital cost control, be exempted from the hospital reimbursement provisions of this bill, and that this waiver be granted without prejudice.

We endorse the concept of rewarding hospitals whose routine costs are below the average of their groups, and penalizing hospitals whose costs exceed the group's average.

But the classification of hospitals into groups differentiated only by bed capacity seems inflexible and unwieldy. More sensitive criteria may be needed, to account for geographical differences, different sponsorship, and variabilities in level of care that is provided. In New York State, for example, the character of the hospital industry in New York City is far different from that in rural areas upstate.

When New York State first sought to control hospital costs in 1970, we began by examining certain routine costs of inpatient care, as this bill does. Many years later and wiser, we have become more sophisticated in our efforts to contain hospital costs. We found that, when certain cost components are left out of a reimbursement formula, these costs often become artificially inflated in an effort to counteract restraints contained in the formula. Thus, when we placed stringent controls on reimbursement for inpatient care, we found that the average length of stay began to increase, and that charges for outpatient and ancillary services shot upward at a precipitous rate. Accordingly, we found it necessary to broaden our cost containment efforts to include ancillary costs, to set standards for average length of stay, and to place a ceiling on reimbursement for clinic and emergency room services. I offer this experience as proof that cost control legislation, if it is to be effective, must cover ancillary as well as routine costs.

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The concept of a conversion allowance is, we believe, an ingenious answer to the problem of unneeded, underutilized hospital facilities. We believe such a provision would overcome the opposition many states have experienced when they have tried to close or consolidate unnecessary hospitals and hospital services. Such efforts, however, should be closely linked to health planning at the state level, and should involve both health systems agencies and state health facilities planning agencies. Through this interface, the states would be in a position to identify those institutions and services that are redundant to need.

Many states have sought permission for hospitals to convert some beds to the level of nursing home beds, with appropriately reduced reimbursement. Heretofore, federal health policy has not permitted this. Thus, we are pleased to endorse this provision in the bill.

And we also endorse the constraints placed on reimbursement of hospital-based physicians, such as anesthesiologists and pathologists, for services not directly related to patient care.

The performance criteria, reporting requirements, and penalties specified in relation to eligibility determination, claims processing, and data retrieval are, in our opinion, unrealistic.

In summary, may I say that we states, much like the Federal government, need to coordinate our cost control efforts with related activities in health planning and development. The proposed legislation could be more supportive of such efforts by closely involving the states with the administration and intent of the legislation. For example, states could be asked to submit administrative programs that would integrate cost control, planning and policy linkages at whatever level they might be currently operating. In some states, this would be development of a strong capital expenditures control system, while in others it would be a coordinated and complex system of rate-setting, planning, and capital expenditures controls. This could be at least partially accomplished through a state administrative program requirement. Such a requirement would need to be supported by Federally-established performance criteria tied to the intentions of the Act, but in keeping with the unique situation of the various states.

Inherent in my testimony is the belief that something must be done immediately to cope with the explosive rise in state and local, as well as federal, governments' share in health care costs. But, at the same time, we need a

long-term approach, such as this bill, to the problem. We believe that considerable attention should be given to increasing state resources so that health care cost containment can be effectively planned, implemented and evaluated.

I want to stress that ASTHO strongly endorses the intentions of this legislation. Our commentary is presented from the perspective of strengthening a useful and necessary proposal.

And if we may be permitted one final observation, it is that the increase in expenditures by the health care delivery system over the past decade has not demonstrably benefited the health status of the American people. We are confronted with rapidly increasing expenditures for new technology, more personnel, new facilities, without a necessary relationship to improved health. In addition to capping the costs of institutional care, we must consider increasing our investment in the prevention of illness and the promotion of good health practices on the part of the populace.

Senator TALMADGE. Our next and final witness today is Mr. Anthony Mott, executive director, Finger Lakes Health Systems Agency, chairman, Legislative Committee, American Association for Comprehensive Health Planning.

Mr. Mott, we welcome you to the committee. We will insert your full statement in the record and you can summarize, if you will.

Mr. MOTT. If we could make one departure, I would like Mrs. Jacqueline Hansen, board chairman of the HSA in Kansas City, to make a presentation.

Senator TALMADGE. We would be delighted.

Senator DOLE. Since Mrs. Hansen is a Kansan, we would be very pleased to have her appear as a witness this morning.

STATEMENTS OF ANTHONY MOTT, EXECUTIVE DIRECTOR, FINGER LAKES HEALTH SYSTEMS AGENCY, AND CHAIRMAN, LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, AND JACQUELINE HANSEN, BOARD CHAIRMAN OF HSA, KANSAS CITY

Ms. HANSEN. Mr. Chairman and members of the committee, my name is Jacqueline Hansen. I am delighted to have this opportunity to appear today on behalf of the Association of Comprehensive Health Planning to testify on Senate bill 1470.

AACHP is organized to foster and encourage health planning across the country at the State and local levels. It represents the interests of those involved in health planning and resources development at the State and local levels: consumers, providers, governmental bodies, and professional health planners.

Organizational membership includes health systems agencies, State health planning and development agencies, and a broad cross-section of business, industry, labor, and universities, as well as several hundred individual members.

I am sure that the members of this committee know the litany of health care costs only too well. National health expenditures tripled between 1965 and 1975. In fiscal year 1976, the annual expenditure for health totalled \$139.3 billion up 14 percent over the \$122.2 billion spent in fiscal year 1975. This rate of increase was approximately twice the CPI for the same period.

The largest expenditure category was hospital care, representing nearly 40 percent of the total at \$55.4 billion. This was a \$7 billion—

14.5 percent—increase over fiscal year 1975. Physicians' services, nearly one-half as large as hospital expenditures, were estimated at \$26.4 billion, an increase of 15 percent over 1975 expenditures.

Continued increases of this magnitude jeopardize the availability of reasonably priced quality medical care for all Americans and delay any serious consideration of a national health insurance program.

Any effective program designed to limit the increases in medical care costs must control both the development and the reimbursement of health care facilities and services. AACHP believes that building on the existing certificate of need and rate setting authorities contained in Public Law 93-641, and on the integrity of the Federal, State and regional functions and relationships established under that legislation is the best way of achieving these goals. We believe that S. 1470 takes this approach and for that reason we endorse the fundamental principles embodied in the bill.

As you know, a major contributing factor to the rate of increase in health care facility costs is capital investment. Unnecessary capital expenditures are doubly inflationary. Not only must the public bear the development, construction and financing cost of unnecessary facilities, but it must also pay the significantly increased operational cost generated by those facilities.

Thus, while efforts are undertaken to control increase in operating costs through the introduction of measures designed to encourage efficiency among health care facilities, efforts should also be made to achieve other compatible basic changes in the health care system.

Specifically, unnecessary expenses for facilities and services should be prevented, excess capacity should be diminished, unnecessary utilization of facilities should be reduced, and the public should be educated to the relationship between the proliferation of facilities and services and increases in medical care costs.

A strong systemwide planning program is necessary to address these concerns so that imbalance in the distribution and mix of services and facilities is reduced and additional medical care resources are developed according to true regional and community needs. Without such an aggressive planning program restrictions in reimbursement for operating costs will do little to affect the long-range patterns of increasing health care costs.

Another major advantage of linking reimbursement and resource development controls is that it would more effectively involve wide public participation in the national effort to contain the rise in health care costs. This is important because these efforts will ultimately require highly unpopular decisions which can best be accomplished by maximizing citizen involvement, understanding and support. This is precisely the role of our member agencies.

As we have been most directly involved in the control and appropriate placement of health resources we would like to first speak to the provisions of the bill which directly affect these activities.

We are particularly pleased that S. 1470 contains authority in section 3 for the provision of a conversion allowance for underutilized facilities and services. Such an allowance has been one of the most essential missing ingredients in existing efforts to shrink excess capacity. We do believe, however, that State and local planning agencies should

be provided with a more active role in selecting appropriate recipients of such allowances.

We also applaud the provisions contained in section 4 of the bill which would strengthen the section 1122 review process by increasing the sanctions for unauthorized capital expenditures, and by requiring that proposed capital expenditures in standard metropolitan statistical areas which encompass more than one jurisdiction receive the approval of all designated planning agencies in the area.

We do note, however, that underlying deficiencies remain in the review process under both Public Law 93-641 and section 1122. Specifically, we believe that the following additional provisions should be introduced:

One, the establishment of a national capital expenditures ceiling; while we cannot confirm the accuracy of the \$2.5 billion ceiling contained in the administration's cost control proposal, our experience suggests that only a relatively low ceiling will allow us to achieve the rationality required. We believe the \$2.5 billion suggested by the administration to be generous.

Two, the establishment of national supply guidelines. We accept the suggested maximum of 4 beds per 1,000 population and the 80-percent occupancy factor contained in the administration's cost control proposal as general guidelines. Application of such "standards" as a ratio of 4 beds per 1,000 population, coupled with the 80-percent occupancy rate requirement, is a reasonable step in the right direction.

We wish to stress, however, that both guidelines must be viewed from a national perspective. Minimum requirements should not, in fact, become the norm. The health care delivery system in more than one-fourth of the Nation already functions more efficiently than the guidelines specify. Great care must be taken to avoid laxity or retrogression in areas that are already functioning relatively efficiently.

In this connection, we would point out that the old Hill-Burton occupancy norm, which many people felt was too lax, stipulated an average occupancy factor of 85 percent.

Three, the extension of controls on capital expenditure to all facilities, including Federal Government facilities.

Four, the inclusion of all expensive equipment in the range of \$150,000 and above, regardless of location. Without this inclusion, planning, service delivery, and capital expenditure computations becomes distorted.

Five, the inclusion of explicit authority for decertification and/or conversion of facilities and services to assure success.

Six, the inclusion of provisions for discontinuation of FHA loan guarantees, tax-free bonding authorities or investment credits, or any other incentives for capital formation for unapproved facilities and equipment;

Seven, the inclusion of provisions specifically requiring that project approvals be consistent with the health facilities plans, State health plans, and national guidelines described in Public Law 93-641.

We also regret that DHEW is not currently compensating our member agencies for performing section 1122 review. The effectiveness of the review process depends in part on the payment for the functions required by that process.

With regard to the provisions of S. 1470 which are designed to impact on reimbursement principles we are strongly supportive of the principles contained in a number of provisions.

We support section 2 which calls for both an accounting and uniform functional cost reporting system as well as the classification of hospitals for purposes of limiting reimbursement. Additionally, we support the provisions which prohibits hospitals from increasing other charges to compensate for reduced medicaid and medicare reimbursement. Private patients should not be the victims of the regulatory process.

Moreover, we are pleased with the role of planning agencies in determining whether the adjusted per diem payment rate should apply to the portion of a hospital's routine operating costs attributable to the underutilized capacity, as well as the waiver provided to State rate-setting programs under section 222 of Public Law 92-603 and 1233 of the Public Health Services Act. However, we believe that individual planning agencies could be given a role in suggesting criteria for the hospital classification described in section 2.

We also specifically support section 10 of the bill which encourages physicians to accept assignments under medicare, Section 11 dealing with limitations on prevailing charges under medicare, and section 15 which authorizes the development of relative value schedules to be used in reimbursement.

These provisions are important in our view because they begin to give legislative recognition to the fact that comprehensive policy and planning cannot occur without addressing physician remuneration in a more rational fashion.

Nevertheless, we should not lose sight of the fact that such remuneration is substantially less important than the other medical costs which are controlled, but not received, by physicians. We must, therefore, also intensify our efforts to reduce unnecessary utilization of facilities and services and develop effective alternatives to inpatient facilities and services.

Finally, we would like to lend our support to the provisions in the bill relating to the streamlining of the administration of medicaid. We believe these provisions will help eliminate the second-class medical care which has all too often been the unhappy fate of those who require medicaid assistance.

Mr. Chairman and members of the subcommittee, this concludes our remarks. We reiterate our support for the principles involved in S. 1470. We believe that they merit consideration not only in relation to medicare and medicaid but as a model for desired changes across the entire health care system.

We look forward to working with you on the enactment of the bill as well as on other key issues of mutual concern.

Thank you.

Senator TALMADGE. Ms. Hansen, I believe you are the chairman of the board of directors, Mid-American Systems Agency?

Ms. HANSEN. Yes.

Senator TALMADGE. How many members do you have?

Ms. HANSEN. We are a 30-member board made up of 51 percent consumers, 29 percent providers. I am a consumer member of the board.

Senator TALMADGE. How many States?

Ms. HANSEN. We are in two States, a five-State agency. We represent five Missouri counties, three Kansas counties in the statistical area of Kansas City, Mo.

Senator TALMADGE. Do you think this bill is a step in the right direction to try to control the very rapid escalation of medicare and Medicaid?

Ms. HANSEN. I do, Senator, partly because it has in it provisions for the utilization of the already existing health planning network, although it is a network, as you well know, in a developmental stage and a planning stage, I think it is an appropriate means by which health care costs can be controlled.

Senator TALMADGE. If you have any further recommendations to improve the bill, we would appreciate your submitting them in writing.

Ms. HANSEN. Thank you.

Senator TALMADGE. Senator Dole?

Senator DOLE. I have only one question, based on paragraph No. 2 on page 4 that ends on page 5, with reference to the four beds per 1,000 and the 80-percent occupancy requirement.

What has been your experience in the eight counties that you are active in as far as occupancy? Does that cover any rural counties?

Ms. HANSEN. Partially rural, Senator. We have part of Platte, some parts of Cass and Clare are considered rural and other parts of Leavenworth are considered rural. We are a mixed region in that way.

We do not approach that kind of occupancy in the eight county metropolitan area. I would be naming the number. I guess overall, considering the 29 inpatient facilities in the region, somewhere about 72 to 75 overall.

Senator DOLE. Is it lower in the rural areas, the occupancy rate?

Ms. HANSEN. I think not, I think it is lower in the central city area where we have clusters of facilities. They are uneven in their occupancy. Some are very much full most of the time. Others are finding it less easy to provide the same quality of service and obviously it has resulted in some lessened demand.

We are an overbedded area, however, in terms of the needs.

Senator DOLE. You support the provision.

In rural areas I think there is some flexibility. We have the swing bed provision that indicates that you can use some of those beds for long-term care. Do you see that as a satisfactory provision?

Ms. HANSEN. I think again, in my experience, being a local experience, I would have to view it on a case-by-case situation. In our region, I think it is certainly a reasonable alternative rather than allowing a capital expenditure that already has been made to be put to no function while over here, a long-term care institution is being constructed.

I think it is a rational alternative to be considered.

Senator DOLE. That is the way Senator Talmadge views it, and I think that is the way others of us view it.

If you have the facility, it makes little sense to go out and build another.

Ms. HANSEN. It is true.

However, Senator, sometimes you do find in an inpatient facility that it is inappropriate for long-term care because of the building. That comes down to specifics. But in general, it is an excellent principle.

Senator DOLE. I appreciate very much your testimony.

Senator Talmadge has indicated if you have any plans, or if you have an opportunity to read the testimony of the witnesses that will be here the rest of this week and have any suggestions or comments on that testimony, it will be helpful.

Senator TALMADGE. Thank you very much, Mrs. Hansen and Mr. Mott. We appreciate your contribution to the committee's deliberations.

Tomorrow we will hear from representatives of the Nation's hospitals.

The subcommittee will stand in recess until 8:30 tomorrow morning.

[Thereupon, at 11:20 a.m. the subcommittee recessed to reconvene at 8:30 a.m. Wednesday, June 8, 1977.]

MEDICARE AND MEDICAID ADMINISTRATION AND REIMBURSEMENT REFORM ACT

WEDNESDAY, JUNE 8, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 8:30 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Matsunaga, and Dole.

Senator TALMADGE. The subcommittee will come to order.

The first witness this morning is Mr. John Alexander McMahon, president, American Hospital Association, accompanied by Mr. Alan Manzano, vice president and Leo J. Gehrig, senior vice president.

Gentlemen, we are delighted to have you. Your entire statement will be inserted into the record and, if you will summarize it in 10 minutes, we would appreciate it.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY ALAN MANZANO, VICE PRESIDENT AND LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT

Mr. McMAHON. Thank you, Mr. Chairman.

As you noted, I am Alex McMahon, president of the American Hospital Association, accompanied by Dr. Leo Gehrig and Mr. Allan Manzano.

The AHA represents more than 6,500 member institutions, including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, hospital schools of nursing, and over 24,000 personal members. We appreciate the opportunity to present our views and recommendations on S. 1470, the Medicare/Medicaid Administrative and Reimbursement Reform Act.

The AHA believes that your bill, S. 1470, Mr. Chairman, identifies and constructively addresses a number of critical issues important to the public, providers, and Government in the provision of health care services. Central among these issues is the rapidly increasing cost of health care services.

Hospitals are concerned and are working actively to restrain health care cost increases within their control. Health care cost increases are a complex problem; to address the issue requires the combined efforts

of all providers, consumers and Government and other third-party payers. Therefore, as we seek to bring the increase in health care costs in line with the growth of the general economy, it is essential that the actions taken be constructive to this end, and it must be recognized that this objective cannot be accomplished in a relatively short time.

What is forgotten is the fact that these 6,000 hospitals are governed by 100,000 community-oriented trustees who are very, very concerned, just as you are in the Congress and as other people are, about the rate of increase in cost. Sometimes, the allegations of what is going on in hospitals overlook the dedicated service of these trustees, many of whom both of you Senators know from your own States and your own communities. Hospitals are ready and willing to reduce costs, but not at the expense of reducing quality or turning away patients.

It is essential that the actions taken be constructed with all the ends in mind and it must be recognized that cost reduction objectives cannot be accomplished in a short timespan.

Hospital cost increases result from a variety of factors. On page 2 of our statement we have set forth, as we see it, the difference in impact of inflation on the economy as a whole versus that on the hospitals' market basket and the services that lead to the increase in cost.

We know that you recognize the unique characteristics of the health care delivery system, Mr. Chairman, and our analysis indicates that S. 1470 reflects an understanding and consideration of its complexities. S. 1470, in revising the method of payment to hospitals, establishes a system of incentives and disincentives based on target rates for groups of essentially similar hospitals. We strongly support the provisions allowing State rate review programs to serve as an alternative method for control over medicare and medicaid payments. In addition, we support your efforts not only to make improvements in the medicare reimbursement system, but also your efforts to improve the current medicaid program.

The approach of your bill, Mr. Chairman, which considers the operational differences between institutions, is a reasonable and equitable one that deals rationally with cost problems, unlike the inequitable and harmful approach proposed by the administration's bill, S. 1391. In your introductory remarks on S. 1470, you expressed several concerns about the administration's proposal which we share. We have concluded that S. 1391 is inequitable in design, wrong in concept, and impossible to administer.

If the committee would like, we can expand on that later on.

On pages 4 to 6, Mr. Chairman, we have noted some of the present hospital controls as well as hospital activities designed to reduce the rate of increase. We have touched upon the importance of planning and on the existence of capital controls and we have suggested the use of incentives to eliminate unneeded facilities. We are pleased with the provisions of your bill dealing with this matter. I will have more to say about that later.

Even unneeded facilities, Mr. Chairman, we must recognize, are depended on by some people. It is one of the reasons why it is difficult to say that there are a lot of excess beds or unneeded facilities, when the elimination of those would mean that some people would then have to go without.

We have touched on utilization, review, and medical audit. We have spoken favorably about the anti-fraud and abuse provisions which you began and which are now moving forward in the Congress.

We have talked about the impact of State rate review. We have noted the excessive regulation problems. We have suggested greater public disclosure of costs and charges. We have commented on the problem of patient demand, how the encouragement of better health practices could be a contributor to lower rates of increase in hospitals, as well as health care costs.

We have touched upon the individual hospital efforts. We have noted that we would certainly support reasonable efforts to go further, as we did in the testimony on your bill last year, and as we hope to do today.

The balance of the testimony, Mr. Chairman, deals with S. 1470. It is basically supportive with a few suggestions which, we believe, would improve the workability of the approach. We began the discussion of that on page 7.

We believe that the provisions, Mr. Chairman, of section 2 would result in significant improvement of the existing methodology of section 223 of the 1972 amendments, which it is intended to replace, and we strongly support the provision in the bill that permits State rate review programs as an option to the bill's federally administered controls. We are pleased with the addition of those provisions which we take as responsive to our suggestions last year. However, the proposal we think—and we noted this, Mr. Chairman, on page 7—is a narrow delegation to the States because of the requirements that delegation would be only to those States where hospital payments would be less than would be paid under the Federal program, are perhaps too restrictive.

Governors would have difficulty in determining whether or not they could meet that challenge. We think probably, with the present situation of the rate review programs, broader opportunity for delegation would be advisable, and we noted that.

On page 8, we have commented favorably on the proposal for uniform functional costs reporting systems without the requirement of a uniform functional accounting system. We think that uniform reporting will deal with the problem. Of course, a problem basic to the workability of the classification system is the need to get uniformity of reporting.

Toward the bottom of page 8 we begin noting the number of recommendations which we believe, as I said earlier, would make the provisions of the bill more workable and I would like to highlight several of them.

In the middle of page 9, under item 3, we noted that the proposed system of classification continues to be based on bed size and type of facility. We suggest a consideration of other variables, such as case mix and length of stay which would provide more flexibility.

On page 11, under point 7, we suggested a somewhat broader exception process because the assessment of intensity and complexity of care, as we noted on the bottom of the page, in addition to patient mix, would add a needed flexibility and would give opportunity to expand on the evaluation of the workability and classification system.

On page 12, we expressed a concern about the possibility that, over time, the incentive formula, the average per-diem cost within a group of comparable institutions which may have a ratchet effect. We suggested a 2-year review.

We might also, and will discuss this further with the staff, Mr. Chairman, consider the use of the median rather than average to make the system more workable.

We have suggested, at the bottom of page 12, two important issues, the first being a provision for charity care and bad debts incurred by hospitals. Some attention might be given to that—medicare and medicaid might share in the cost of treating all unsponsored patients.

We have suggested at the bottom the need to provide for the financing of necessary replacement of hospital plant. The problem of surplus revenues, or an operating margin, Mr. Chairman, is not understood as the testimony of the Secretary yesterday seems to indicate. Section 46 addresses another question, and we must provide for the effect of inflation on working capital and provide the equity needed for the improvement of plant or replacement of wornout facilities.

Mr. Chairman, hospitals, as a whole, do not have a surplus, an operating surplus—hospitals as a whole, across the field—we have tracked this for a number of years, the field operates at an operating loss. What does bring about excess of revenues over expenditures are non-operating revenues, donations, and so on, that make it possible for expansion; and this is an absolutely necessary part of hospital operations.

Finally, Mr. Chairman, from pages 13 through 17, we have offered comments on other sections. We were particularly pleased with several sections, such as section 3, to encourage the closing and conversion of unneeded facilities, and section 24, the conversion of unneeded acute beds in small institutions.

We made a minor suggestion or so on that. We are not quite sure, I will say, Mr. Chairman, that we completely understand the new sections 12, 15 and 40, although we do see improvement over the earlier version and will be pleased to work with the committee staff on needed clarification.

Finally, Mr. Chairman, as I noted in the concluding remarks on page 17, we believe that your bill includes many constructive and important reforms in administration and reimbursement for services under medicare and medicaid programs. We support them and have suggested some modifications, and we do appreciate the opportunity to continue to work with you and your staff and in participating in this hearing.

I would be glad to respond to questions.

Senator TALMADGE. Thank you very much, Mr. McMahon, for your very helpful testimony.

On page 12, you express concern over a possible ratchet effect on average hospital costs under the reimbursement plan in the bill. Do you believe that that would occur because the average cost would be reduced as above average high cost hospitals brought their costs down?

That, of course, would tend to lower the average when it was next calculated. I agree that we should avoid forcing the average down to unfair and inequitable levels, but Secretary Califano testified yes-

terday that the proposal would not have much of a moderating effect on hospital costs.

I gather that your stand is just the opposite, that we might moderate hospital costs too much. Is that what you are saying?

Mr. McMAHON. We are concerned—well, it really goes to the workability, Mr. Chairman, of the incentive activity. If you take an average and then give the incentive for the hospitals to come below the average through an award, we are not sure on what the effect of that on the average as well as the effect through the elimination or the reduction of rate of increase of the high costs will have. That is the reason that we have suggested the possibility of the use of a median which would avoid what I am talking about.

It might be useful—why we suggested what we did in the testimony, the reevaluation very 2 years might be useful. We are concerned. We know it is going to have a very positive effect, Mr. Chairman, in focusing on and giving notice to the institutions who are above, substantially above, the average to bring themselves in line.

I think this is a very useful concept, because it zeroes in on those where savings are possible and we are convinced that that program will have a beneficial effect.

Dr. GEHRIG. May I add to that?

As Mr. McMahon has stated, I think this is going to have a very positive effect. I think it is important to note that the plan in the bill would provide, prior to initiation, data for hospitals to look at. I believe its effect will occur before, in fact, it becomes fully in force, because it would have provided fuller data to hospitals in which those costs are high. They can begin to make management changes prior to the effective date of this bill and adjust accordingly. It will have a real effect in moderating costs. It will occur early.

Senator TALMADGE. We are concerned with the need for accurate measures and methods for hospital wage levels in geographical areas. Both you and the Department of Health, Education, and Welfare, say that such methods are not now available.

HEW says, however, that they can be developed in a reasonable period of time. If these methods are not now available, what yardsticks do you people use who say that hospital wages are too high, too low, or average?

Mr. McMAHON. Mr. Chairman, we have always thought that the issue there is one to be determined by the institution itself. Again, as I say, governed by those community-oriented trustees who are very much concerned, both about the rates of increasing costs and about the ability to obtain and retain qualified people.

We have had some experience and tracked very closely, Mr. Chairman, some of the impact of section 223, and we know that hospitals in a specific community are influenced by activities outside of that community.

For example, you may have a State institution in a relatively moderate wage-level community, but it is tied to its own State wage programs and cannot really be measured by that community wage level. There are other problems as well.

When the need comes to recruit nurses out of that community, we have always been very careful to try to measure or make comparisons

about the wage level from institution to institution, because we know what the problems are.

We pointed out in the testimony, as you note, there are some problems with that concept. We have no solution at this stage. We would certainly be pleased to work with you and the staff to see what we might be able to do.

Senator TALMADGE. Thank you for that suggestion.

Should the wages of nonprofessional hospital employees be in a class by themselves, or is it reasonable to relate them to general wage levels in a given geographical area, or similar areas?

That is, are there not broad types of employment related to the work which janitors, electricians, orderlies, and administrative and clerical personnel do in hospitals?

Mr. MANZANO. We do not have specific data on a national basis on what those wage comparisons are, but there are indications, when you are talking about classifications of employees that are representative of the general employment market, that is a market in which hospitals must compete, their wages are generally comparable.

Senator TALMADGE. Is it not reasonable to use those as benchmarks?

Mr. MANZANO. In the case of classifications of employees that are represented in the general wage market, it would be, yes, Mr. Chairman.

Senator TALMADGE. Senator Dole?

Senator DOLE. Thank you, Mr. Chairman.

I think Mr. McMahon touched on the administration proposal. We are not having a hearing on that as such, but you might briefly tell us, at this point, what you think the principal defects are in that approach, the approach that Secretary Califano discussed briefly yesterday and also your comments or suggestions, if any, on having the Comptroller General take a look at what they are attempting to do in reorganization.

I might say GAO is already starting that investigation. They are going to start at 2 o'clock this afternoon with a meeting with the Finance Committee Health Staff. Your comments might be helpful.

Mr. McMAHON. All right. Let us take those, Senator Dole, one at a time.

When one from the hospital field tries to pick a beginning point to analyze the administration's proposal, one is at a complete disadvantage, because it is all bad. Whether you are talking about the use of a specific percentage or whether you are talking about this extremely complex system that the bill sets forth, the whole thing is based upon a series of misunderstandings and miscomprehensions of the ways hospitals work.

For example, the Secretary said that 20 percent of the hospitals are already below 9 percent and he does not see why the others cannot do so. When you look at it, hospitals vary so greatly that those who are in a steady state, you might say, operating at about the same occupancy, providing the same services, ought to be under 9 percent.

An institution, as you know, that I am familiar with, will operate at less than a 9-percent increase next year, but it will not the following year, when some new services come into play.

The difficulty is, in many institutions, they are undergoing changes, changes in services, changes in patient mix, changes in the services that they provide for the community or changes in the community itself. It is that attempt to use a single yardstick that leads me to say that the bill is unworkable in concept.

I have also said that it was administratively impossible. You start off a year under the administration's proposal, and you are given a target, but that target is subject to change during the year. It is subject to change if the number of admissions change, and also because it says that we assume the same patients will come in next year as last year. This makes it impossible to adjust as circumstances change.

You do not know, Senator Dole, until well into the second year whether you have met the compliance requirements of the first year, because it does not do away with retrospective cost reimbursement. You are given a target and then you have to go through the accounting for the year and into the second year, make your calculations to find out whether you did meet the targets of the first year.

Nobody can budget under those circumstances. It would make the management of the institution absolutely impossible.

On top of that, you have the imposition of a class of purchaser concept, medicare, medicaid, the Blues, the commercial carrier are given some targets to meet with no recognition of the fact that their subscriber or insured or beneficiary mix might change.

For that reason, with the supervision of the third parties coupled with the managerial problems that make this the absolutely worst mish-mash we have ever experienced. It even goes beyond the so-called phase 4 of the economic stabilization program. That we found very difficult because it, again, was based on the assumption that a hospital operates in similar fashion from year to year, and that just is not the case.

We think that the only way to deal with the problem of the rate of increase in hospital costs is to understand first, why they increase; second, what the differences are from institution to institution. That, then, will enable you to say, as the bill that is the subject of this hearing does, let us begin by focusing in on the high cost of what seem to be high-cost institutions and make our savings in those areas first, giving notice, and target through an appropriate classifications scheme.

If there are further aspects of these problems the committee would like to examine or the kind of example that I have tried to sketch out of what happens over the course of a couple of years or to see why we say that the institution would be unmanageable and the third-party relationships impossible, we would be glad to submit that.

As far as the reorganization, of course, we have seen this only from the outside. I was aware of the testimony of yesterday. I have been aware of some of the reorganization plans and the criticism laid against it.

We have been so worried about other aspects of the administration's activity that we have not tracked that as closely as we might have.

Senator DOLE. You know, there was some comment yesterday—I guess "fat" is an easier word to understand than "obese." Do you have any fat hospitals in your association?

Mr. McMAHON. Mr. Dole, it would be impossible to answer that in the negative. I am sure that there are areas where savings are possible. I am sure that there are savings in the areas, each of us know. But to say that all institutions are similarly obese or fat or inefficient is to say that they all similarly efficient or slimmed down.

It is just inappropriate, inaccurate, and does not contribute to the solution. The reason I mention those trustees, along with the professional administrators, and now, fortunately, the medical staffs, I have seen more concern on the part of medical staffs in recent years than ever before. They are becoming acquainted with their hospitals' budgets, with their hospitals' financial problems, because they are absolutely dependent upon the hospital for the care of their sickest patients.

We have seen more concerned administrators and concerned medical staffs working together to see how increases in costs can be contained.

Unfortunately, for too many people involved, particularly the physicians—this is a new exercise, because the total concern used to be, let us have everything available in case something goes wrong. Now we are beginning to see that that probably imposes—not probably, but it does impose—too large a bill on the public, on the Government, on the third parties, generally.

We are beginning now to look at ways in which some of those standby activities can be eliminated, but once again, it is dependent upon judgment, dependent upon people to make appropriate decisions.

Senator DOLE. My point was, do you have any control, if you see an area where costs are perhaps excessive, and where there may be some ways to reduce them?—What can you do as an association if you find such a hospital?

Mr. McMAHON. We have no control, but we certainly have been pointing out illustration after illustration in our publications and bulletins, in our cost containment manual, the manual for cost containment committee, pointing out areas where we know some institutional savings have been made, and suggested that those areas be looked at, whether they be staffing patterns or the use of service contracts as opposed to employed labor, and so on.

Our responsibility, as we see it, is to provide information to the management of institutions as to areas that they might find further savings.

Senator DOLE. Not only provide information on what they may receive, but also what they may be able to do without?

Mr. McMAHON. Yes.

This is the reason why we have spent a lot of time in the planning area in urging more care before capital expenditures are made and in the sharing of services, and we have seen it is a result of those encouragement efforts, seeing substantial progress made in all of those areas.

Senator DOLE. You talk about State review programs, not necessarily mandated by law. I guess the obvious question is, how can we insure compliance if the rate control program is only voluntary?

Mr. McMAHON. Again, I imagine, Senator, because of the peculiar nature of the hospital field, the programs have been extremely workable. Quite often, it is the old business of leading a horse to water.

When you have the hospitals in the State working together, it tends to bring others into line. There has been, for a number of years in Indiana, a voluntary program that has been quite workable. What we have suggested is, let's take a look at it. We have a lot to learn about State rate review programs and we think the broader the delegation—we do not think if the Federal Government would delegate, whether a mandatory program, mandated by law, or a voluntary program, that you are going to find much difference in the ultimate payment by medicare and medicaid over what would otherwise be the case.

We think the evaluation that can take place, because they are doing things in different ways, might have a very beneficial effect of showing what kind of approaches seem to work the best, not that we would say that a voluntary program over a long period of time would be appropriate, but some of the voluntary programs are using different mechanisms to control rates of increases in cost and in charges.

We think it would be worth looking at them, too. It is a question, even in the voluntary program, of the peer pressure itself, not unlike this committee's longtime interest and involvement in professional standards of review organizations on the political side, the same kind of peer review on administrative costs.

We are convinced that would have a very strong and beneficial effect.

We are saying, the more delegation that there is, because we are convinced that it will not lead to excess payments, then we will all be able to see what kind of rate review mechanisms directed at individual hospitals work the best and bring about the best balance between the reduction in the rate of increase in cost, on the one hand, and an appropriate improvements in the quality of care over time on the other.

Senator DOLE. I think, finally, you talked about the need for comparing hospitals, considering variables other than size and types. I think in the bill itself, on page 4, subparagraph (iii) and subparagraph (viii) on the bottom of page 9, as well as paragraph (c) (1), you will find the language of those three references would authorize the inclusion of any justifiable variables of possible costs. Perhaps if you have any comment, you would submit it for the record.

Mr. McMAHON. We will take a look at it. I think our concern went to the idea that we were not at all sure that that, in effect, did not mean other criteria of the same kind as size and geography.

If it does what we are talking about, then obviously—except, you know, sometimes we do have difficulty and the Congress, I am sure, is aware of it, too, of having the spirit of something carried into effect by an administration that has its own priorities.

We would always be more comfortable with some spelling out before you get to other considerations or other criteria, other criteria such as patient mix, length of stay and the things that would give us then some thing to hang our hat on as we went to encourage the people in the Department of HEW charged with the administration to take into account some of these other matters.

We will take a look at that, and offer additional comment.

[At presstime no additional comments had been received.]

Senator DOLE. It just has been called to my attention it is spelled out in some detail in subparagraph (c) (1) which begins on page 10 and concludes on page 11, the top of page 11, "Costs similar in terms of size or scale of operations and prevailing wage levels."

You might just review that, and if you have any additional comments—

Mr. McMAHON. Our reading of that section of the bill, however, dealt with the expansion of the program—an expansion, incidentally, that we are pleased to see, because we think it carries a useful concept into other areas. We thought that was only reflecting how improvement might be made in the ancillary services. We will take a look at that.

Senator DOLE. It does affect rural areas, not just in the state of Kansas where we are pretty healthy, but in other states where it would be important and your suggestion would have merit.

Dr. GEHRIG. We would like to follow up on the point you just made as to regard to what the bill covers. I think we are a little sensitized, however, because under past legislation, in section 223, there was defined a number of areas that should be considered in that classification scheme that were ignored by the Department.

It has been a problem. Maybe we are overreacting. That has been a problem for us in the past.

Senator DOLE. Thank you.

Senator TALMADGE. Mr. McMahon, we appreciate your helpful testimony. As you know, the Georgia Hospital Association is one of the leading in the Nation in its field.

[The prepared statement of Mr. McMahon follows:]

STATEMENT OF MR. JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Summary

I.

The American Hospital Association represents more than 6,500 health care institutions, including most of the hospitals in the country, and over 24,000 personal members. In this testimony, we comment on Sections 2, 3, 4, 12, 15, 20, 30, 31, 32, 33 and 40 of S. 1470. We recognize the thoughtful and constructive approach of this bill, and we support a number of its provisions. We recommend several modifications to the bill as introduced and propose some additional provisions.

II. BACKGROUND

At the outset, we discuss the overall problem of rising health care costs and some of the major factors that have contributed to increases in the cost of hospital care. Further, we point out that solutions to these problems must take into account the unique characteristics of the health delivery system and provide appropriate incentives for efficient operations consistent with the needs of the American people for access to quality health care. Finally, we oppose arbitrary percentage caps on hospital payments as proposed in S. 1391.

III. COST CONTAINMENT APPROACHES

In this section of our statement, we include a variety of governmental and private approaches aimed at conserving our health care resources, which are supported by the American Hospital Association. These approaches include some programs which are already in place, but need further development and improvement, and others which are in a formative stage, such as S. 1470. We believe they will result in more effective use of health care resources.

IV. SECTION 2

We review the provisions of this section and offer several specific recommendations for improvement of the methodology described therein. In addition, we suggest the inclusion of provisions recognizing the need to assist hospitals in caring for unsponsored patients.

V. SECTION 3

We support the provisions of this section which encourage hospital efforts to close or convert underutilized capacity through special reimbursement incentives.

VI. SECTION 4

We strongly support strengthening the health planning process through the certificate-of-need process, and we recommend broadening this review process to include all sites which provides services usually rendered in a hospital. We also recommend the use of existing procedures under P.L. 93-641 for the coordination of review activities in interstate SMSAs, rather than the mechanism contained in this section.

VII. SECTIONS 12, 15 AND 40

The AHA is concerned with actions which would limit the administrative prerogatives of hospital management. We understand that in connection with these sections, efforts are continuing for developing certain definitions and relative value schedules for use in the payment of hospital-associated physicians. We are hopeful that these actions will provide a satisfactory solution to this very difficult problem.

VIII. SECTION 20

While we support the "swing bed" provisions in this section of the bill, we recommend that the eligibility requirements for hospital participation be expanded.

IX. SECTION 30

The AHA supports the reorganization provisions of this section and further recommends the creation of an Under Secretary for Health with the responsibility for coordination of all HEW health activities.

X. SECTIONS 31 AND 32

We strongly support the administrative reforms in the state administration of Medicaid and the requirement for an adequate time for comment on program regulations.

XI. SECTION 33

We believe that the use of expert, nongovernmental advisors has contributed significantly to the development and implementation of federal health programs. We recommend that either HIBAC be continued with increased responsibilities, or that a new health insurance policy advisory council be established.

XII.

Concluding remarks.

STATEMENT

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me today are Leo J. Gehrig, M.D., Senior Vice President, and Allen J. Manzano, Vice President of the Association. The AHA represents more than 6,500 member institutions, including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, hospital schools of nursing and over 24,000 personal members. We appreciate the opportunity to present our views and recommendations on S. 1470, "The Medicare/Medicaid Administrative and Reimbursement Reform Act."

BACKGROUND

The AHA believes that your bill (S. 1470), Mr. Chairman, identifies and constructively addresses a number of critical issues important to the public, pro-

viders and government in the provision of health care services. Central among these issues is the rapidly increasing cost of health care services. Hospitals are concerned and are working actively to restrain health care cost increases within their control. Health care cost increases are a complex problem; to address the issue requires the combined efforts of all providers, consumers, and government and other third-party payers. Therefore, as we seek to bring the increase in health care costs more in line with the growth of the general economy, it is essential that the actions taken be constructive to this end, and it must be recognized that this objective cannot be accomplished in a relatively short time.

Hospital cost increases result from a variety of factors. These include inflation in the general economy, the intensification and improvement of services, modernization and maintenance of service capacity, expansion of manpower resources, increased demand for services, and compliance with government regulations. Although the Consumer Price Index (CPI) reflects inflation in the general economy, it is inappropriate as an index of the impact of inflation on the goods and services that hospitals must buy. Moreover, the CPI does not reflect the impact of increased intensity of hospital services. The hospital market basket includes many items that have risen much faster than the CPI.

The AHA, therefore, has developed a hospital cost index (HCI) and a hospital intensity index (HII) which are based on the price and utilization of 37 service elements which are common in the delivery of care to patients. These more typically reflect the hospital market basket. Using these indices, we have found that of the 15 percent rise in hospital costs last year, 10 percent was purely the result of inflation. The remaining 5 percent resulted from increased intensity and improvement in patient care.

We know that you recognize the unique characteristics of the health care delivery system, Mr. Chairman, and our analysis that S. 1470 reflects an understanding and consideration of its complexities. S. 1470, in revising the method of payment to hospitals, establishes a system of incentives and disincentives based on target rates for groups of essentially similar hospitals. We strongly support the provisions allowing state rate review programs to serve as an alternative method for control over Medicare and Medicaid payments. In addition, we support your efforts not only to make improvements in the Medicare reimbursement system, but also your efforts to improve the current Medicaid program.

The approach of your bill, Mr. Chairman, which considers the operational differences between institutions, is a reasonable and equitable one that deals rationally with cost problems, unlike the inequitable and harmful approach proposed by the Administration's bill, S. 1391. In your introductory remarks on S. 1470, you expressed several concerns about the Administration's proposal which we share. We have concluded that S. 1391 is inequitable in design, wrong in concept, and impossible to administer.

S. 1391 would require use of uniform percentage limits on increases in revenues, without regard to individual hospital situations. Such an approach would exert the heaviest pressures where they are the least appropriate—on the most efficient hospitals. An efficient hospital would be forced to curtail essential services and sacrifice the quality of care in order to survive within the formula constraints set forth in S. 1391. It is our belief that such a cap is arbitrary in nature and could have the unintended effect of rewarding hospitals for past inefficiencies or preventing many hospitals from making essential improvements in their services. Additionally, S. 1391, as a "short-term expedient," would create distortions in the financing and administration of hospital services which would have serious and long-term adverse impact on the delivery of health care.

Payment reform is only one part of an array of government and private programs under development or in existence that deal with the problems of health care costs. The American Hospital Association is committed to the pursuit of a reasonable solution to this problem which promotes efficiency and does not jeopardize access to delivery of quality health care. While we have stated the opposition of the AHA to the Administration's hospital cost containment bill, we are by no means negativistic with regard to viable alternatives for the containment of health care costs. Neither do we feel any less committed to seeking solutions to the nation's problems of health care costs than is the federal government.

COST CONTAINMENT APPROACHES

Our Association has consistently supported a variety of programs aimed at conserving the nation's health care resources, some of which are in place, some

in developmental stages, and others yet in the process of formulation through legislative and administrative initiatives, state and federal. Among them are the following:

1. AHA vigorously supports comprehensive health planning and the development of local community planning. Our Association has urged and continues to urge the development of strong certificate of need laws at the state level to avoid the development of duplicative or unneeded health resources and to coordinate the allocation of available resources. Planning efforts must be continued and broadened. We are pleased to note that S. 1470 recognizes that success with eliminating unneeded capacity requires that account be taken of the costs associated with conversion or closure of beds. This bill has taken a positive approach to making possible the correction of maldistribution of resources.

2. AHA supports the development of improved utilization review and medical audit. We have worked for the development of cost effective, institutional quality assurance programs as part of Professional Standards Review activities, which can be important in the identification and analysis of areas of high hospital utilization. Where such utilization patterns are inappropriate, corrective action should be taken and can have a beneficial impact on health care expenditures.

3. AHA fully supports anti-fraud and -abuse legislation to strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs, as embodied in your bill, S. 143 (also in H.R. 3).

4. The AHA believes that an effective state rate review system can assure the public that hospital costs and rates are reasonable and appropriate. Such state systems can provide for individualized hospital review, consideration of community characteristics and coordination with local planning decisions. Such rate review programs must include the participation of all payers and recognize the legitimate financial requirements of hospitals necessary for the provision of services to their communities. Furthermore, such state-based review systems permit the development and testing of alternative payment methods and the evaluation of their effectiveness.

5. AHA believes that the government has an obligation to analyze the cost benefits of regulations it imposes on hospitals. As we have stated in the past, government regulations have significantly contributed to the cost of hospital care—for example the continual revision of the Life Safety Code. These and other regulations often have been imposed with significant cost impact but without commensurate improvement in health care or safety.

6. We understand and accept the need for greater public disclosure of hospital cost data. We support collection and disclosure of such information in order to enable the public to make more informed choices in the use of health care services, as well as to better understand the nature of hospital costs.

7. Another factor that has contributed to the increase in health expenditures is patient demand, often unrestrained because of a lack of direct financial involvement. We support exploration of the restructuring of copayments and deductibles to stimulate greater consumer cost consciousness in decisions to utilize health care services. Such restructuring must be carefully designated in order not to impose inappropriate financial barriers to care upon those with limited resources.

In addition to all such cost containment approaches, the American Hospital Association and its member hospitals have sought and continue to seek ways of conserving health care resources. Many hospitals across the country, in addition to their usual management activities, have developed special cost containment efforts. While the Association does not at this time have a complete picture of these activities, our information from many sources points out savings through projects which will have continuing long-term benefits, as well as projects that result in one-time savings. These efforts include a wide variety of approaches such as the conversion or closure of underutilized resources; the development of shared services with other institutions; changes in the methods of providing hospital support services; and cost savings changes in hospital staffing patterns.

MEDICARE/MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT, S. 1470

Criteria for determining reasonable cost of hospital services

We have carefully reviewed the hospital reimbursement changes outlined in Section 2 of your bill. When a classification system is used for the purposes of

reimbursement on a comparative basis, it must be sufficiently sophisticated to permit differentiation of efficient and inefficient hospitals. We believe that the provisions of Section 2 would result in significant improvement over the existing methodology of Section 223 of P.L. 92-603, which it is intended to replace.

We appreciate your recognition that certain hospital costs must be excluded in order to assure comparability. Your bill eliminates, for purposes of cost comparison, the costs of capital, education, energy, and malpractice insurance.

While the bill provides for the exclusion of malpractice insurance expense from the determination of routine operating costs, a significant problem remains in the application of this exclusion. Commercial insurance companies insure hospitals against malpractice under a single policy which includes coverage for both professional and comprehensive general liability. Because it will not be feasible to identify the specific costs of malpractice insurance alone, we strongly recommend that this exclusion include the total cost of such policies.

Mr. Chairman, we strongly support the provision of your bill which permits state rate review programs as an option to the bill's federally administered controls. However, the proposal would permit delegation only to state programs which are legislatively mandated, and we urge that you amend this provision to recognize voluntary programs which meet other established criteria.

One of the conditions for state delegation requires that the estimated aggregate annual Medicare and Medicaid payments by the state to hospitals be less than would otherwise be paid under the federal programs. We are extremely concerned about this requirement. Many state rate review programs are still in the developmental stage, and it would not be unusual for such programs, in coping with overall costs in their early years, to permit an annual payment higher than would be allowed by the federal programs. We believe that similar constraints in Sections 222 of P.L. 92-603 and 1526 of P.L. 93-641 are important reasons for the very limited development of and experience with these alternative payment systems. In a similar manner, S. 1470 provides that the delegation of rate review authority to a state be revoked if it is determined that in any one-year period, except in extraordinary circumstances, the state program results in payments greater than would otherwise have been made by the federal programs. We believe that such rigid requirements for delegation to states, or revocation of delegation, will have the effect of stifling the development of state rate review programs, which, over time, can achieve the goal we all seek. We recommend that this section be modified to allow the Secretary more flexibility in permitting the state rate review options, taking into account longer-term results of such delegation.

We commend you for proposing a uniform, functional cost reporting system without the requirement that there be established a uniform functional accounting system. We agree with the need to identify "like" costs of institutions. Such a reporting requirement is a prerequisite in your classification system and is used in the determination of inpatient per diem target rates. The position of the American Hospital Association has been and remains that a uniform functional cost reporting system will accomplish this objective. Last year, S. 3205 would have required "a uniform system of accounts . . ." and in our testimony on that bill, we pointed out the problem that such a requirement would create. Because of the differences in the nature and operation of various kinds of hospitals—urban and rural, large and small, teaching and non-teaching—the requirement for a uniform functional accounting system would have required each of these institutions to adopt a singular method for recording all transactions that would be burdensome, extremely costly and unnecessary.

We offer the following recommendations that we believe will improve the provisions of Section 2 of your bill and we are ready to participate in further discussions toward that end:

1. In defining routine operating costs, the bill eliminates several items that are, in fact, beyond the control of an institution and have, in the past, created difficulties in using a classification scheme. The objective in excluding these costs is to remove from the determination of routine operating costs major "cost elements beyond the control of the hospital" which vary widely among institutions in a way which is unrelated to the efficiency of the institutions. We agree with this. However, at some future date other cost elements meeting the same criteria may appear and should be similarly excluded. Therefore, we strongly recommend that this provision be modified to permit the Secretary to deal with such circumstances as they arise.

2. Among the costs to be excluded from routine operating costs are "energy costs associated with heating and cooling the hospital plant." We believe all energy costs must be excluded for two reasons: (1) there is a significant variability in types of energy sources used by hospitals and their costs in various regions of the country; and (2) differentiation of the cost of energy by type and use is very difficult, if not impossible. For example, electricity, which is used for environmental control, particularly cooling, is also used for the operation of diagnostic and therapeutic equipment, as well as lighting.

3. The proposed system of classification continues to be based on bed size and type of facility. While these variables can account for certain aspects of hospital routine operations, others such as case mix and length of stay, are necessary to truly classify "like" hospitals.

We recognize the inherent problems of developing and utilizing such data in any classification system. Further, the state of the art of determining and comparing these extremely important variables, as they relate to cost, requires further development. It is essential that evaluative procedures for analysis of the effectiveness of the payment method be carried out on a continuing basis. Such activity will be important to ensure that the basic classification and exceptions processes cover all appropriate factors and that the entire procedure can be improved.

4. The bill provides that the personnel component of average per diem routine costs be adjusted through the use of a wage index based on general wage levels prevailing in the areas where the hospitals are located. As expressed last year, our concern is that this index refers to wage levels in the general economy rather than the segment of the labor force from which hospitals recruit their employees. It must be pointed out that the correlation between these wage levels is not even approximate because in any hospital, employees' wage levels are not representative of wage levels in a cross section of the general economy. Moreover, to the best of our knowledge, wage data of nonmetropolitan areas are not available on a periodic basis, and it is in these areas that approximately 50 percent of all hospitals are located.

Although a hospital with higher wage levels than those prevailing in the general economy of its area would have a one-year reprieve under the bill, it would be subjected to controls thereafter that fail to recognize that those higher levels of cost may be fixed, for example, by virtue of prior contractual arrangements, or may well be maintained by state or local law, as in the case of public institutions. Again, we recommend that a new hospital wage index be developed and maintained based on that segment of the labor market from which hospitals must recruit.

5. Section 2 provides that "... at the end of the fiscal year retrospective adjustments will be made in the amount paid a hospital to reflect the lesser of the cost increases incurred by the hospital or the cost increase in practice which occurred in goods and services used . . .". The problem with this provision is that a hospital could be told at the beginning of the fiscal year that it would be reimbursed at a certain dollar level per patient day for its routine services, and budget accordingly. But, if at the end of the year the government determines that the forecasted price increase was in error, and, therefore, that the hospital should be paid at a level lower than that previously set, the institution would subsequently incur a deficit. We do not believe that hospitals should be placed at such risk. The system should not permit a retrospective denial of reimbursement of incurred costs on the basis of erroneous economic forecasts.

6. We concur with the use of a uniform data base period, i.e., Fiscal year 1979, in establishing the target rate for Fiscal 1981. As you know, in projecting payment rates it is essential that the base data be as accurate and as reflective as possible of actual situations. However, the proposal is silent concerning adjustments to base data in recognition of institutions' varying fiscal years. We believe that this is not your intent, and we recommend that a varying inflation adjustment be incorporated in the proposal that would reflect the inflation factor during an institution's actual fiscal year.

7. Section 2 provides an exceptions process based on two criteria. The first exception is for an underutilized hospital in a medically underserved area. The second exception is for increased intensity of care or unusual patient case mix. One of the problems faced by hospitals with unusual case mixes and high levels of intensity of care, is that they do not have the necessary comparative data to justify their costs. We have observed that hospitals seeking exceptions from

the limitations imposed under Section 223 of P.L. 92-603 for this same purpose experience this difficulty. They must attempt to justify atypical costs without knowledge of the amount or nature of such costs for other hospitals in their peer grouping. We recommend that the bill provide that the HEW Secretary make such comparative data available to all hospitals within a classification group.

Furthermore, the assessment of the intensity and complexity of care provided by the institutions include, in addition to patient mix, such variables as length of stay. Hospitals with high patient turnover and shorter lengths of stay are usually characterized by higher intensity and per diem routine costs, and we strongly recommend that these factors be included as justification for exception.

8. We continue to be greatly concerned about the provisions that would tie the incentive reimbursement formula to average per diem costs within a group of comparable institutions without provisions for evaluating and altering an unwarranted "ratchet" effect. If, as intended, the results of the incentive formula would be that each year average per diem costs would potentially be reduced, additional hospitals not previously found to have high costs would be so identified and penalized. This would be the inevitable consequence each fiscal year of cost reductions in hospitals classified in the highest category. Unless provision is made to deal with this effect, the eventual result would be that costs related to the provision of needed, complicated and, therefore, costly health services would no longer be recognized. Thus, the delivery of such services would no longer be feasible in many health care institutions. We recommend that legislative language be included to ensure that this matter be reviewed every two years after the system is applied, so that the system may be evaluated and modified accordingly.

9. Two important issues are not addressed in Section 2 of the bill. The first is the provision of charity care and the bad debts incurred by hospitals. Un-sponsored patients are a serious problem to hospitals because of the increasing stringency of state programs and because of the decline in the ability of local governments to finance the care of their medically needy patients. This problem is critical, and a solution must be found. We believe the time has come for both Medicare and Medicaid to acknowledge and share in the costs of treating all unsponsored patients.

The second issue not addressed is the need to provide for the financing of the necessary replacement of hospital plant as it wears out and for needed improvements. Paying hospitals only their operating costs will not be sufficient to provide them needed capital funds or permit them to secure debt financing at realistic interest rates, if needed, they can qualify for loans at all. We are anxious to work with the Committee to devise methods for addressing these issues.

Payments to promote closing and conversion of underutilized facilities

We support, Mr. Chairman, the need to provide special reimbursement provisions to encourage hospital efforts to close or convert underutilized facilities. AHA strongly endorses the experimental approach in Section 3 of the bill.

Federal participation in hospital capital expenditures

Section 4 of the bill amends Sections 1122 and 1861 of the Social Security Act, relating to the health planning process. Under P.L. 93-641, most, if not all, states will have a certificate-of-need program in place by 1980. We support the provision in the bill that would strengthen the health planning process by expanding the reimbursement penalties applied to providers who proceed with capital expenditures without planning approval. We do believe, however, that the application of the certificate-of-need requirement should be broadened to include capital expenditures at any site when such expenditures are made for equipment or services customarily provided in a hospital setting.

We understand the purposes of the provision in this section that requires designated planning agencies to jointly review and approve a proposed capital expenditure in a standard metropolitan statistical area (SMSA) which encompasses an interstate area. However, we are also concerned that this provision may block needed action in these areas because it may involve in the review process a designated planning agency which is primarily interested in supporting improvements only in its own area. In view of the fact that P.L. 93-641

currently has mechanisms available to coordinate project reviews in SMSAs crossing state lines, we recommend deletion of this provision.

Hospital-associated physicians/use of approved relative value schedule

While we are concerned that the degree of intervention in hospital-physician agreements suggested in Sections 12 and 40 of your proposal may unduly affect hospital management flexibility and the availability of needed professional services, we note that S. 1470 includes the use of relative value schedules under Section 15. It is our understanding that such schedules would provide a basis on which to determine reasonable reimbursement for the professional services of hospital-associated physicians. We also understand that the staff of the Committee is continuing to develop recommendations related to important features included in this provision. We are hopeful that these efforts will result in a satisfactory solution to this very difficult problem.

Hospital providers of long-term care services

Section 20 of the bill provides incentives for the use of underutilized acute hospital beds for needed skilled nursing services. While we strongly support this section of your bill, we do believe that the conditions imposed on hospital participation are unduly restrictive. By limiting this provision to hospitals with 50 beds or less, and with an occupancy rate of 60 percent or less, we anticipate that some facilities in communities with a serious shortage of skilled nursing beds will be ineligible to utilize their capacity efficiently through this "mixed use" of their beds.

We recommend that the benefits of this proposed change in current law be available to hospitals with up to 100 beds with an average occupancy level of not more than 75 percent.

Establishment of health care financing administration

As you have stated, the Administration, through Executive Order, has created a Health Care Financing Administration (HCFA), combining in a single entity the Bureau of Health Insurance, the Medical Services Administration, the Bureau of Quality Assurance, and the Office of Long-Term Care and related research and statistics units under the direction of an administrator. We concur with your intent in Section 30 to ensure that the objectives of your provisions are carried out in the new HCFA. However, we are still concerned that the HCFA, which is intended to provide an organization through which greater coordination of policy and program administration can be achieved, cannot of itself resolve the problems of coordination of overall federal health policies. As we stated last year, we urge even greater coordination of federal health programs and recommend that a new position of Under Secretary of Health be established. This would permit the Assistant Secretary for Health and the Administrator of the HCFA to report to an Under Secretary for Health, and in this way, coordinate the many HEW health programs.

State Medicaid administration

Section 31 of the bill would establish specific performance criteria with respect to state administration of Medicaid. Requirements related to the timely determination of eligibility, prompt payment of claims, quality control and eligibility determinations, and effective claims review could result in better state administration. We strongly support such measures to improve Medicaid administration. However, this proposal establishes a 45-day period for state eligibility determinations. The time frame in S. 3205 was 30 days. We would recommend that the 45-day period be changed back to a 30-day period, because we believe this to be an adequate time for states to meet this requirement.

Regulations of the Secretary

Under Section 32 of the bill, a minimum of 60 days would be provided to comment on proposed HEW regulations under this provision. The American Hospital Association has always been concerned that appropriate time be provided for comment on program regulations, and we strongly support this provision.

Termination of HIBAC

Section 33 would terminate the Health Insurance Benefits Advisory Council (HIBAC). We believe that the use of expert, nongovernmental advisors through HIBAC has contributed significantly to the development and implementation of federal programs, and consider it important that the major health care programs

of Medicare and Medicaid be provided the advice and assistance of such an advisory group, particularly during a period of significant legislative and program changes. HIBAC served an important and useful role in the earlier development and implementation of Medicare. As a result of the changes in the responsibility of this advisory council in 1972, the evolution of the program, and the extent to which its advice has been sought and utilized in recent years, the role of the council has decreased. Nevertheless, such an advisory council should be available not only for its potential contributions during the reform of Medicare and Medicaid, but also for the development and implementation of any major revisions in Social Security health-related legislation. Therefore, we strongly recommend that either HIBAC be continued with increased responsibility for its advisory role or, if it is discontinued, that a new health insurance policy advisory council be formed, with more adequate authority and responsibility for advice to the Secretary about these programs.

Procedures for determining reasonable cost and reasonable charge

Last year, Section 40 of S. 3205 would have vested with the Secretary of HEW authority to determine in advance the reasonableness of all hospital contracts greater than \$10,000 annually. Its deletion from S. 1470 is an appropriate and administratively realistic change.

However, Section 40 of the proposal would still eliminate, as an element of reasonable cost, those costs derived from a percentage or fraction arrangement. As we have stated before, this requirement interferes unnecessarily with hospital management prerogatives. There are situations in which the use of this method of calculating payments for services is an equitable and justifiable arrangement. Present law provides the Secretary with the authority to deny payment for costs when they are excessive. Sections 12 and 15 of the bill appear to deal with a reimbursement method for hospital-associated physicians and, therefore, the provisions of this section may no longer be needed.

CONCLUDING REMARKS

In summary, Mr. Chairman, we believe your bill includes many constructive and important reforms in the administration and reimbursement for services under the Medicare and Medicaid programs. We support them and have suggested some modifications. We appreciate the opportunity to continue to work with you and your staff and to participate in this hearing. I will be pleased to answer any questions you may have.

Senator TALMADGE. Our next witness is Mr. John A. D. Cooper, president, Association of American Medical Colleges, accompanied by David D. Thompson, M.D., director, the New York Hospital, chairman, Council of Teaching Hospitals; and James D. Bentley, assistant director, department of teaching hospitals.

We are delighted to have you.

Dr. Cooper, you may insert your statement in full in the record and summarize it in 10 minutes.

STATEMENT OF JOHN A. D. COOPER, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY DAVID D. THOMPSON, M.D., DIRECTOR, NEW YORK HOSPITAL, AND CHAIRMAN, COUNCIL OF TEACHING HOSPITALS, AND JAMES D. BENTLEY, PH. D., ASSISTANT DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS

Dr. COOPER. Thank you very much for this opportunity to testify. With your permission, our testimony will be delivered by Dr. David Thompson who is the director of New York Hospital and chairman of our Council of Teaching Hospitals.

Dr. THOMPSON. Mr. Chairman and members of the committee, as Dr. Cooper says, I am Dr. David Thompson, chairman of the Council of Teaching Hospitals of the Association of American Medical Colleges and director of the New York Hospital. Dr. Cooper and Dr. Bentley are accompanying me this morning.

The Association of American Medical Colleges is pleased to have this opportunity to testify on the Medicare-Medicaid Administrative and Reimbursement Act, S. 1470. In addition to representing all of the Nation's medical schools and 60 academic societies, the association's Council of Teaching Hospitals includes over 400 major teaching hospitals. These hospitals: account for approximately 16 percent of the admissions, almost 19 percent of the emergency room visits, and 29 percent of the outpatient visits provided by non-Federal, short-term hospitals; provide a comprehensive range of patient services, including the most complex tertiary services; and are responsible for a majority of the Nation's graduate medical education programs. Thus, the medicare and medicaid amendments proposed in S. 1470—concerning hospital and physician payments and program administration—are of direct interest and vital concern to the association's members.

A review of S. 1470 clearly shows that the subcommittee and its staff have given careful consideration to suggestions made by witnesses during past hearings on possible medicare and medicaid amendments. Several improvements have been made in these proposed amendments, including increased flexibility in the classification of hospitals, the addition of malpractice insurance costs to the list of expenses excluded from routine operating costs, and the establishment of provisions for relative value scales for physicians' services. For these modifications and for the staff's willingness to discuss general concepts and tentative provisions of S. 1470 the AAMC expresses its appreciation to the subcommittee and its chairman.

In the interests of brevity, I will confine my oral statement to two concerns: the legislative specificity of the bill and teaching hospital concerns for hospital classification, case mix, and exception provisions. I would request, however, that our comprehensive written statement be included in the record of this hearing.

The medicare program was established on the principle of paying individual hospitals their reasonable costs for caring for program beneficiaries. As a result of escalating program expenditures and observed variations in reasonable costs, S. 1470 has been designed to moderate and limit hospital costs by determining allowable payments based on comparing similar costs of similar hospitals.

Grouping similar hospitals to determine payment ceilings is one legitimate approach for containing the rate of increase in hospital costs. It is handicapped, however, by the absence of necessary data for computing the impact of alternative provisions and by the elementary state of the art of hospital classification. Within these constraints, the association believes the subcommittee and its staff have worked diligently to create workable legislation.

While the association is pleased that S. 1470 provides the executive branch with some increased flexibility in implementing the congressional intent, the Association of American Colleges remains concerned that some specific grouping criteria, such as bed size categories, are

initially designated in the bill. Similarly, while no one knows what the actual distribution of hospital costs by group will look like, the association is concerned that the 120-percent ceiling is established without these distributions. With these detailed provisions in the legislation, learning acquired through experience can only be incorporated by future amendments. In a proposal for a significantly revised payment program; the association believes this problem is critical and strongly recommends that the bill be modified to provide more flexibility.

To avoid the possible consequence that flexible legislation give Executive agencies unbridled opportunity to restructure the program, the association recommends that a more flexible bill be accompanied by a clear statement of intent in the committee report and by providing in the legislation for a high level advisory group: a National Technical Advisory Board on hospital classification for developing, advising, and implementing the act. This Board should serve in an advisory capacity to the Secretary of HEW, should conduct all meetings in public sessions, and should publish all recommendations.

For approximately 2 years, the association's staff has worked with the staff of this subcommittee in an attempt to adequately define teaching/tertiary care hospitals and to examine the impact of establishing a special category for these institutions. Given the present state of the art and the lack of necessary quantitative information, our own efforts thus far have been unsuccessful: We have neither simple criteria for selecting such a group nor an evaluation of the effect of creating a category for them.

In this situation, the association strongly recommends that the subcommittee modify the present provision establishing a category for the primary affiliates of accredited medical schools. First, if such a category is to be established, the limitation of a single hospital per school is arbitrary and does not accurately recognize the number of tertiary care/teaching hospitals that presently exist. Second, the principal source of atypical costs in the major teaching hospitals results from the scope and intensity of the services provided and the diagnostic mix of the patients treated, not from the presence of an educational relationship with the medical school. Therefore, the AAMC strongly recommends modifying or deleting the provision for the primary affiliates of accredited medical schools.

If Congress determines that a special group of tertiary care/teaching hospitals is initially necessary, the Secretary should be directed to undertake the study effort to determine the category and select institutions for it based on their diagnostic mix, intensity of care provided, and involvement in health, manpower education. Moreover, it is recommended that the Secretary be required to undertake studies to determine and evaluate the extent to which tertiary care hospitals have atypical costs as a result of the diagnostic and treatment services provided; as a consequence of providing necessary services having high unit costs; as a result of educational expenditures; and as a consequence of ancillary service utilization and ancillary unit costs.

The association strongly supports the case mix provision provided in S. 1470. Tertiary care/referral hospitals serve the more severely

ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic activity. Recognition of these facts in the legislation should help to insure the economic integrity of tertiary care centers.

Experience gained since the development and initial operation of section 223 of the 1972 medicare amendments shows the need for a viable and timely exception and appeal process. Such an appeal process does not function under the present section 223 provisions. The association recommends that this legislation include provisions for an exception and appeal process that provides: (1) That information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of comparable hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed, widely disseminated and easily accessible to all interested parties in each circumstance; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay may result in an increase in the hospital's routine per-diem operating cost with no change or reduction in per-admission costs.

In the interest of brevity I have only highlighted the association's response to S. 1470. As the subcommittee and staff address these issues and others, the association would be pleased to provide constructive comments and suggestions.

Thank you for permitting me to testify before you in support of the bill. I will be happy to answer any questions.

Senator TALMADGE. Thank you very much, Dr. Thompson. We know that your hospital is one of the great teaching hospitals in the Nation. We appreciate your very helpful and very constructive suggestions. Many of them, I feel sure, the committee will consider carefully.

In your statement, you expressed extensive concern over the need to assure an adequate supply of pathologists.

I am curious as to exactly how percentage arrangements enhance the practice of clinical pathology. That is, would you not agree that most doctors are motivated toward radiology, anaesthesiology and pathology for professional reasons rather than because they get a percentage of the gross receipts?

Dr. THOMPSON. Yes, sir. I think that is correct. I think most individuals select the specialty in which they are engaged on the basis of their professional interest.

I think the manner in which the payment mechanisms developed go back in tradition. The percentage arrangement is something that seemed to work for some of the hospitals. Many of the smaller hospitals found that they were unable to recruit individuals, perhaps because they did not have a full-time need for them, and they adopted this approach.

I think everyone agrees today that this is a situation that needs to be looked at. The concern on the part of these specialty groups, I think, is that they not be put in the position where it might seem that they are second-class citizens in relation to other physicians. In other words, the fee-for-service approach which is generally utilized in most specialties, is something that is important to these individuals as well. It does

not necessarily, of course, require the fee on any percentage arrangement.

I would hope that the committee, and I know they are, and the staff, are working with the various associations. It is my understanding that an agreement in principle as to the approach that should be taken is being developed. I am pleased to note that.

Senator TALMADGE. How are pathologists paid in your particular hospital?

Dr. THOMPSON. In our hospital pathologists are all on a salary basis. This is by no means uniform, as you know, but it has been traditional in our hospital.

Senator TALMADGE. I think we have worked out an agreement with all three of your professional groups that they will be paid on a fee-for-service basis, based upon a relative value scale. Do you agree with that?

Dr. THOMPSON. That seems to be a reasonable approach. It is not a simple issue.

Working with the societies that understand the concerns I believe will result in an equitable and reasonable approach. At least, it seems that way to me.

Senator TALMADGE. That would be an alternative. You could still be an employee on a salary basis if it is mutually agreed by the hospital and by the doctor.

Dr. THOMPSON. I believe so.

Senator TALMADGE. Thank you.

Senator DOLE?

Senator DOLE. I just have a very broad question. It probably cannot be answered.

We hear all of the time that the free market does not work in the medical care arena because the patient does not pay the bill, he does not select the goods and services or the facilities in which these facilities are rendered. Of course, the patient does pay the bill through a combination of premiums, higher prices, and taxes.

What he really has are a number of agents that pay the bill on his behalf. These are the insurance companies or the Government.

Why can the free market not operate in the medical care area?

Dr. THOMPSON. I think that what we are about, perhaps, basically distinguishes the situation. I do not think that ideally in the medical realm you are looking to develop a competitive industry in the sense of seeing which one can provide the product at the least cost.

I think what we are hoping to accomplish is more of a cooperative effort, that institutions working together will be able to supply the services that are needed to the public, that not all hospitals will necessarily provide the same services.

The economies that can be achieved in the industry really depend upon that cooperative approach and I think that this will be helped as the regionalization develops, as the health systems agencies become more involved and more knowledgeable about it. It seems to me that these are the ways in which the hospital industry can be shrunk so that unnecessary duplication will be avoided.

For these reasons, I do not see it in the same light as I do the automobile industry, for example.

Senator DOLE. Thank you very much.

Senator TALMADGE. Are there many unnecessary beds in New York City?

Dr. THOMPSON. Yes, sir, there are.

There have been many studies by a variety of agencies over the years and it is interesting that most of them have come up with roughly the same conclusion: that there are probably in the neighborhood of 4,000 or 5,000 excess beds. This is certainly not restricted to New York City. There are national figures that have been developed as well. I am more familiar with New York.

I think it is important to point out, for purposes of economy, a closure of beds scattered throughout all of the hospitals does not have as much savings as the closing of total institutions. That is a difficult matter to do for a lot of reasons, political and otherwise, as you know. Nonetheless, I think that it is recognized in New York in order to accomplish this objective, some hospitals will have to close.

Senator TALMADGE. That is a very significant issue, Doctor. If you have any ideas that you could share* with our committee staff, we would be grateful.

Dr. THOMPSON. We would be delighted to do that.

Senator TALMADGE. Do you think it is appropriate for the burden of financing the cost of training residents, interns, and nurses in hospitals to fall upon the sick people through payments for hospital care?

Dr. THOMPSON. The issue in regard to interns and residents, as you know, Mr. Chairman, has been widely discussed. It is our view in the teaching hospitals that this is an appropriate cost. As you know, the interns and residents are students; no question about that. They are there to develop under supervision. The average individual, after receiving his medical degree, spends nearly 4 years in this postgraduate period before he is really ready to practice independently. At the same time, the individual as a student is, of course, providing significant patient services.

The interns and residents work 60 to 70 hours a week, most of them, night and day, and that is essentially for their education as well as provision of services.

In my view and from my understanding in talking to the public, they understand that this is a necessary cost to be borne to produce the next generation of physicians. Otherwise, they will not have well-trained physicians. That is terribly important to them.

So I think that it is very much justified. I think that the situation with nursing is a little different. It depends on the particular educational arrangement that one has. There are still, today, hospital schools of nursing and the students do provide significant patient services. Some of the nursing schools have gotten away from the provision of services and I think a question might be raised there whether or not it is appropriate for that to be paid out of the health care dollar.

What concerns me is that we need these people very much and some mechanism of payment needs to be provided and I do not see any substitution for that, Mr. Chairman. I think it is absolutely essential that in some form these educational programs continue to be supported.

Senator TALMADGE. Do you have any suggestions for a more equitable means of paying the necessary medical and nursing education

and training costs in hospitals rather than putting these costs on the backs of the sick?

Dr. THOMPSON. I really do not know, Mr. Chairman, of any other method. It seems to me that no matter which pocket it comes out of these costs need to be borne. It seems to me that it is essential for the future of patient care, so I think that if one does split it out of the health care dollar, there is really a serious question as to whether or not it will be supported or whether the various agencies will argue about whose responsibility it is. In this situation those institutions which are providing that education are going to suffer, and ultimately the public.

Dr. COOPER. May I add a comment here?

As the cost of medical care is spread broader and broader throughout the population on the basis of insurance, really it is not just the sick who are in the hospital who are paying the course of graduate medical education. Actually, the public generally is bearing the cost of the preparation, as Dr. Thompson has said, of the next generation of physicians. And so that it is not just the sick in the hospital that are involved, but the entire population in assuring that they have adequately trained physicians for the next generation of care.

Senator TALMADGE. As you know, that is a very serious problem. If any of you have any more equitable suggestions that the committee could consider, we would certainly be grateful for your contribution.

Thank you very much.

Senator Dole?

Senator DOLE. I would just like to raise one question. Is it true that the hospital schools of nursing are on the decline?

Dr. THOMPSON. Yes, sir, it is. While the hospital schools are on the decline, the baccalaureate programs are on the increase. Actually, there has been an increase in the number of graduates.

The reason for this, Senator Dole, I think basically is as the practice of medicine has become more complex, so has the practice of nursing and the educators have found that they need to have educational programs in nursing which are somewhat longer and more extensive, more scientifically developed, than was the case in the past. So there is definitely the trend toward having a baccalaureate program.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, gentlemen, for your very helpful and constructive testimony.

[The prepared statement of Dr. Cooper follows:]

STATEMENT OF DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Summary

I. HOSPITAL PAYMENT PROVISIONS

A. Uniform cost reporting

1. AAMC supports the provisions of Section 2 requiring uniform hospital cost reporting.

2. AAMC urges that the Committee Report state that the provisions of S. 1470 do not require or authorize the establishment of mandatory uniform hospital accounting.

B. Classification of hospitals

1. AAMC recommends more flexible legislation providing that hospitals "be classified by type and size" with specific guidance in the Committee Report.
2. AAMC recommends appointment of a "National Technical Advisory Board" to recommend and evaluate classification systems.
3. AAMC strongly recommends deleting the present provisions establishing a specific category for the "primary affiliates of accredited medical schools".
4. AAMC strongly recommends that the Secretary of HEW be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals".

C. Determining routine operating costs

1. Where cross-classification schemes for determining hospital payments are used, the AAMC supports removal of atypical and uncontrollable costs.
2. AAMC supports more flexible legislation which would permit additions to the list of excluded costs without new legislation.
3. AAMC recommends providing Executive Branch with flexibility to specify payment ceiling with guidance in the Committee Report.
4. AAMC recommends permitting wage rates to be used as the basis for an exception where a hospital can demonstrate that it had to pay atypical wage rates to recruit personnel.
5. AAMC supports case-mix provisions.
6. AAMC recommends provisions for exceptions process.

D. State rate control authority

AAMC finds state rate systems are acceptable where they meet specific organizational and operational characteristics.

II. PHYSICIAN PAYMENT PROVISIONS

A. Defining "Physicians' Services": AAMC recommends amending S. 1470 to explicitly permit "physicians' service" compensation for a physician who is simultaneously functioning as an educator and personally performing or directing identifiable patient care services.

B. Anesthesiology Services: AAMC supports broader definition of anesthesiology services.

C. Pathology Services.

1. AAMC is concerned that the proposed emphasis on fee-for-service payment for surgical pathology services and hemato-pathology services would favor these two areas over other important areas of clinical pathology.

2. AAMC is concerned about payment mechanisms which could possibly discourage the involvement of pathologists and inhibit the development of the discipline.

D. Percentage Fee Compensation.

1. AAMC is concerned that the proposal may inhibit the development of some clinically necessary disciplines by placing them at a disadvantage with others.

2. AAMC requests explicit guidelines for determining "an amount equal to the salary which would have reasonably been paid".

E. Part A Compensation Arrangements: AAMC requests explicit guidelines for determining "an amount equal to the salary which would have reasonably been paid."

III. ADMINISTRATIVE REFORMS

A. Health Care Financing Administration.

1. AAMC supports centralization of Federal health care financing.

2. AAMC advocates Cabinet-level Department of Health.

B. State Medicaid Administration: AAMC strongly endorses more rapid payment to providers.

C. Regulations of the Secretary.

1. AAMC supports 60 day comment period.

2. AAMC requests some guidelines for defining "urgent" regulations.

D. Abolition of HIBAC: AAMC strongly recommends the maintenance of an advisory board to the Secretary of HEW which is composed of providers, practitioners, and consumers from the private sector.

STATEMENT

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the "Medicare-Medicaid Administrative and Reimbursement Act," S. 1470. In addition to representing all of the nation's medical schools and sixty academic societies, the Association's Council of Teaching Hospitals includes over 400 major teaching hospitals. These hospitals: account for approximately sixteen percent of the admissions, almost nineteen percent of the emergency room visits, and twenty-nine percent of the outpatient visits provided by non-Federal, short-term hospitals; provide a comprehensive range of patient services, including the most complex tertiary services; and are responsible for a majority of the nation's graduate medical education programs. Thus, the Medicare and Medicaid amendments proposed in S. 1470—concerning hospital and physician payments and program administration—are of direct interest and vital concern to the Association's members.

A review of S. 1470 clearly shows that the Subcommittee and its staff have given careful consideration to suggestions made by witnesses during past hearings on possible Medicare and Medicaid amendments. Several improvements have been made in these proposed amendments including increased flexibility in the classification of hospitals, the addition of malpractice insurance costs to the list of expenses excluded from routine operating costs, and the establishment of provisions for relative value scales for physicians' services. For these modifications and for the staff's willingness to discuss general concepts and tentative provisions of S. 1470, the AAMC expresses its appreciation to the Subcommittee and its Chairman.

The Association is well aware of the fact that spending for health care—as a result of general economic inflation, increased service availability, improvements in service quality, growth and changes in population, and increased per capita utilization—has increased more rapidly in the past two decades than have most other segments of the economy. This fact has focused consumer, industrial, governmental, and provider attention of the nation's health care expenditures. In recent legislation—such as P.L. 92-603 and P.L. 93-641—the Congress has attempted to establish programs and policies which will help stimulate a more efficient and effective health industry.

It should be emphasized that the present levels of hospital costs have developed over a long period of time and as a result of hospital responses to national and state legislation, to prevailing economic and social conditions, and to public demands. Thus, the Association is pleased that Senator Talmadge, in introducing S. 1470, described it as "... a long-term basic structural answer to the problem of rising hospital costs ..." To reduce the increase in hospital costs, the AAMC supports the position that a long-term approach is needed, and critical comments made in this testimony are submitted with the intention of strengthening the proposed legislation.

Amendments concerning hospital payments

Uniform cost reporting

A most important prerequisite for the proper measurement, evaluation, and comparison of hospital costs is the development and implementation of a system of uniform cost reporting. Therefore, the Association supports the provisions of Section 2 of S. 1470 requiring uniform hospital cost reporting.

Some organizations and government officials have argued that uniform reporting requires mandatory uniform accounting. The Association does not support this contention. That uniform reporting data can be provided without mandatory uniform accounting has been demonstrated by several state rate control agencies and by non-hospital industries. Therefore, the Association urges that the Committee Report accompanying this bill clearly state that the uniform reporting provisions of S. 1470 do not require or authorize the establishment of mandatory uniform hospital accounting.

Classification of hospitals

A fundamental concern of the Association is the criteria used to establish any hospital classification system used to calculate hospital payments. While the Association is pleased that S. 1470 provides the Executive Branch with increased flexibility in implementing the Congressional intent, the AAMC remains concerned that some specific grouping criteria—such as bed size categories—are initially designated in the bill. Recognizing that there is a lack of data available for analyzing the impact of these grouping criteria, the AAMC believes a more

prudent approach would be to permit some additional flexibility with which to construct the system. Therefore, the Association recommends that S. 1470 state that hospitals "be classified by type and size" with specific guidance in the Committee Report, rather than stipulate the specific bed categories and types of hospitals prior to the availability of adequate data for examining the effects of such classification variables.

It is further recommended that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review program progress, monitor program implementation, examine problems encountered and make recommendations regarding appropriate solutions for problems identified. The advisory board to be established should include representatives from the Legislative and Executive Branches of Government, as well as knowledgeable individuals from the private sector. In addition to its technical expertise, this advisory board would provide public visibility for the decisions implementing these amendments. The Association's experience with the implementation of the payment limitations of Section 223 of P.L. 92-603 leads to strongly recommend such an advisory board.

S. 1470 provides for the creation of a separate group of hospitals which are the "primary affiliates of accredited medical schools." It is difficult to evaluate the implications of creating such a group because of the absence of data. Efforts to gain data and experience with a separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be excluded from the proposed scheme. Thus, there is uncertainty as to the relative merits of a separate group for teaching hospitals.

More importantly, the present legislation would restrict the "primary affiliates of accredited medical schools" to a single hospital per medical school. This is a gross injustice to many teaching hospitals. Limiting each medical school to one and only one "primary affiliate" is arbitrary and does not recognize the complexity or the reality of medical education in this nation.

In this situation, the Association strongly recommends that the Subcommittee delete the present provision establishing a category for the "primary affiliates of accredited medical schools." First, no one knows how routine operating costs in teaching hospitals will compare with routine operating costs in non-teaching hospitals. Secondly, the principal source of atypical costs in major teaching hospitals results from the scope and intensity of service provided and the diagnostic mix of patients treated, not from the presence of an educational relationship with a medical school. Third, if a separate category is to be established, the limitation of a single hospital per school is arbitrary and does not accurately recognize the number of "tertiary care/teaching hospitals" which presently exist.

In the absence of adequate data and operational experience to evaluate the proposed classification scheme and to avoid arbitrarily limiting the "primary affiliates of accredited medical schools" to one hospital per school, the Association believes that the combination of a flexible classification system and an adequate phase-in period are essential elements of the program's chances for success. Thus, the Association strongly recommends that the Secretary of the Department of Health, Education and Welfare be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals." Instead of prescribing a pre-defined grouping for teaching hospitals, it is proposed that the Secretary be required to determine, in consultation with the appropriate knowledgeable health organizations, a definition which most accurately reflects the impacts of case mix, intensity of care, and health science education on the costs of teaching hospitals. In performing these consultations, the Secretary should be required to distribute and share the data upon which alternative definitions are to be evaluated. This is a good example of an issue which would be brought before the proposed Technical Advisory Board.

Determining routine operating costs

In the past, the Association has not specifically advocated a cross classification approach to cost limitations. Rather, if a cross-classification approach is to be used, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product produced or to characteristics of the production process. Therefore, the Association believes that the exclusion of capital and related costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and non-administrative

physicians; energy costs associated with heating or cooling the hospital plant; and malpractice insurance expense is a step in the proper direction.

This present list of excluded costs includes several significant items which make cost comparisons between hospitals difficult either because they are not uniformly present in all hospitals (e.g., stipends for residents), because they are uncontrollable by the institution (e.g., utility rates), or because there is substantial regional variation (e.g., malpractice premiums). However, because today's controllable cost may become tomorrow's uncontrollable cost, flexible legislation including, but not limited to, the costs excluded in S. 1470 is recommended. If conditions change this would permit any appropriate additions to the list of excluded costs without new legislation.

Following a rather complicated calculation, S. 1470 establishes the ceiling for routine service payments at 120 percent of each classification group's average. As we have stated earlier, the present Medicare reporting system does not permit identification of costs to be excluded in computing routine service costs. Therefore, no one knows what the actual distribution of hospital costs by group will look like. The Association believes that a 120 percent ceiling should not be established by statute without knowledge of these distributions. It is recommended that the bill provide some flexibility in determining the ceiling and that the Committee Report clearly state Congressional intent as guidance for Executive Branch action.

The procedure for calculating the reimbursement limitation includes an adjustment for changes in general wage levels in the hospital's geographic area. Because many medical centers must recruit personnel outside of their immediate areas, the AAMC recommends that S. 1470 be amended to add that wage rates may be used as the basis for an exception to a routine operating payment limitation where a hospital can demonstrate that it had to pay atypical wage rates to recruit personnel.

The Association strongly supports the case mix provision provided in S. 1470. Tertiary care/referral hospitals serve the more severely ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic conditions. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/referral centers.

Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends this legislation include provisions for an exception and appeal process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or reduction in the per-admission costs.

State rate control authority

Where the Secretary of HEW and a state enter into an appropriate contract, the bill permits a mandatory state reimbursement system to be used to determine payment limitations. The Federal Government is the source of funds for the Medicare program and shares in the funding of Medicaid; however, apart from an aggregate payment cap, S. 1470 provides no Federal payment or operational standards for the state agencies. On the issue of state rate setting agencies, the AAMC's position is that state rate systems are acceptable where they meet the following conditions: (1) the system is based on the full financial requirements of hospitals; (2) the system is based on an adequately financed, politically independent agency headed by a small number of full-time, well-compensated commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (3) the agency's operations include clearly defined formal procedures, adopted after public hearings, for systematic review of rate or budget applications and with provisions for routine changes to be made with minimal procedure and expense; and (4) the agency provides due process, including the right to judicial appeal for the applicant as well as for others affected by the decisions, and specific protections against undue delays in action.

Summary

Assuring Medicare beneficiaries needed health care services, encouraging efficiency in the provision of health care and paying the full and fair costs of health care providers should be the guiding principles of any reimbursement system. The compatibility of the goals can be maintained under a system which accounts for the many legitimate service and case-mix differences found between hospitals. When this is done, illegitimate costs arising from inefficiency or extravagance, can be isolated. However, if care is not taken to identify the costs of inefficiency, legitimate reimbursement may be threatened and consequently the hospital's ability to provide needed health services will be reduced.

In this regard, one has to be impressed with the thought and effort that went into the provider reimbursement portion of this bill. One is also impressed with the real complexity of implementing the proposal on a national scale. While the Association finds the proposal, with suggested amendments, worthy of support, the Association recommends that we move forward cautiously and under the review and supervision of the recommended Technical Advisory Board.

Physician payment

Defining "physicians' services"

Under present Medicare law, "the term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office and institutional calls . . ." Section 22 proposes to extend the definition to state: "the term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls . . . except that such term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any patient care service unless such service (a) is personally performed by or personally directed by a physician for the benefit of such patient and (b) is of such a nature that its performance by a physician is customary and appropriate."

As presently stated, the amendment could be interpreted to mean that a faculty physician performing or directing personal medical services in the presence of a student is not eligible for a fee for his professional medical services because the physician will be defined as an educator whose services are to be paid on a cost basis. The AAMC is opposed to this interpretation and, therefore is opposed to the present wording of the amendment. Where a faculty physician is simultaneously performing or directing patient care and educational functions, the Association believes that the physician should be eligible either for professional service payment on a fee-for-service basis or for educator compensation on a cost basis. Therefore, the AAMC recommends amending S. 1470 to explicitly permit "physicians' service" compensation for a physician who is simultaneously functioning as an educator and personally performing or directly identifiable patient care services.

Anesthesiology services

Anesthesiologists in the Association's Council of Academic Societies are concerned that the definition proposed in S. 1470 for anesthesiology services could be so narrowly interpreted as to preclude payment for physicians' services traditionally performed by anesthesiologists. Therefore, the AAMC supports amending Section 12(a) (2) of S. 1470 to read as follows: "In the case of anesthesiology services, where anesthesia is administered to facilitate surgery, obstetric delivery or special examinations, a procedure . . ."

Pathology services

The AAMC is concerned about the proposed pathology provisions of S. 1470. The proposed provisions would tend to alter and restrict professional activities and services in clinical pathology. By emphasizing fee-for-service payment for surgical pathology services and hemato-pathology services, the bill would favor these two areas over other important areas of clinical pathology where distinct and medically important services are rendered.

Laboratory Medicine (Clinical Pathology) has become an important specialty of medicine within recent years both in teaching centers and in the community at large. Clinical pathologists provide a variety of services vital to medical care including the following: assurance of quality of laboratory procedures and results; guidance in the use of the laboratory, in the appropriateness of labora-

tory requests and in the interpretation of results; and interfacing between patient care physicians and the laboratory by providing two-way communication in the form of ad hoc consultation to clinicians on a wide variety of laboratory information and feed-back to the laboratory concerning specific clinical needs and problems. In addition to these vital functions, the clinical pathologist provides a broad variety of direct formal consultative functions in hematology, coagulation, microbiology, immunology, blood banking, and clinical chemistry (for example, bone marrow and peripheral blood examinations and reports in hematology).

Clinical pathologists have final medical and legal responsibility for all laboratory reports and verify their reliability. In this capacity, they also take responsibility for analytical validity and for the appropriateness of the methodological approach to the precise clinical needs, and they see to it that appropriate reference values are provided and are continuously reviewed and up-dated.

While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the involvement of pathologists and inhibit the development of the discipline.

Percentage fee compensation

Where the hospital's allowable costs include "the charges of physicians or other persons which are related to the income or receipts of a hospital or any subdivision thereof," S. 1470 proposes that such charges would only be recognized as allowable costs to the extent that they do not exceed ". . . an amount equal to the salary which would reasonably have been for such services . . .". This provision is the focus of two concerns. First, some specialists have traditionally been paid on a basis that is related to either hospital or departmental income or receipts. While not opposed to limiting the open-ended character of some of the compensation arrangements, the Association is concerned that the proposal may inhibit the development of some clinically necessary disciplines by placing them at a disadvantage with others.

Secondly, while the objective of limiting Medicare recognition of charges based on percentage arrangements is clear in principle it is clouded with ambiguities in practical application. The bill includes no indication of the basis on which ". . . an amount equal to the salary which would have reasonably been paid . . ." is to be determined. Certainly the Association realizes and appreciates the desire of the Congress to permit those developing regulations to have some flexibility in implementing this amendment; however, in recruiting and negotiating with the medical staff, the hospital chief executive officer and/or medical school dean must be able to determine the amount of compensation that Medicare and Medicaid will recognize. Therefore, the Association requests that the Subcommittee either modify the proposed amendment to incorporate some specific guidelines for regulations or so specify its intent in hearings and Congressional Reports that those preparing the regulations have a clear and consistent direction for determining a reasonable salary for physicians in employment situations.

Part A compensation arrangements

The apparent purpose of Section 12(c) is to eliminate Medicare and Medicaid recognition of remuneration arrangements between physicians and hospitals in which the physician's fee-based income rate in his professional medical service practice is used as a basis for computing his compensation for Part A reimbursable services. In place of such arrangements, the subsection proposes recognition of ". . . an amount equal to the salary which would have reasonably been paid for such services. . . ." Because this provision includes the same practical ambiguities discussed under percentage fee compensation, the Association reiterates its request for a clear and consistent means for physicians in employment situations.

Administrative reforms

Establishment of health care financing administration

This section proposes a codification of the Federal health care financing function and a unification of administrative entities recently reorganized as the Health Care Financing Administration. The Association supports efforts toward centralization and unification of Federal health care financing. Costs incurred by hospitals which result from diffuse and conflicting administrative and reporting requirements and which add overhead to the provision of direct patient

services should be somewhat moderated by the policy of unification and administrative standardization which should accompany this reorganization.

While the reorganization of the financing functions offers the potential of significant reform in program operations, the Association believes the benefits of this reform are limited by continuing the subordination of the health function within the Department of Health, Education and Welfare. A Cabinet-level Department of Health is needed to serve as the single point of responsibility for the nation's critically important health policies and programs. If a separate Department of Health is not to be presently established, the Association recommends the establishment of an Under Secretary for Health to whom both the Assistant Secretary of Health for Health Care Financing and the Assistant Secretary for Health would report. The Under Secretary for Health would then be the Department's central individual for all health matters.

State Medicaid administration

The reform of state Medicaid administration to provide more rapid payment of health care providers is strongly endorsed by the Association. Because of delays in Medicaid payments to hospitals, health care providers in many states have had to borrow funds at substantial interest rates to provide adequate cash flow. These additional interest costs add to the nation's health care expenses without contributing to the direct provision of personal health services. Decreasing the time required for Medicaid payments should contribute in at least a small way, to moderating the nation's health expenditures as well as to reducing the tension between hospitals and state governments.

Regulations of the Secretary

The Association understands and shares the general Congressional concern with present procedures for proposing, evaluating, and publishing Federal regulations. The provisions of Section 32, which would establish a 60 day comment period for regulations, are a much needed reform in this area. Sixty days will allow time for a more thorough evaluation and review. Moreover, it will enable individuals and groups to collect appropriate data to illustrate and substantiate their comments and to offer constructive suggestions. To help ensure that the Subcommittee's intentions are achieved, the Association recommends that some clarification or definition be provided in the Committee Report for the term "urgent" as it applies to the regulations. The Association would also like to emphasize that this reform should not be limited to Medicare and Medicaid programs alone. This Committee and others in both the House and the Senate are urged to consider the need for this reform and others in the area of administrative procedures for the publication of rules and regulations.

Abolition of HIBAC

The Health Insurance Benefits Advisory Council (HIBAC) was established in the original Medicare legislation as a mechanism for providing the government with private sector advice on the implementation and operation of the Medicare program. At least in its early days, it served this function well and helped make legislative language into a workable program. The provisions of S. 1470—especially those concerning hospital and physician payment computations—make major changes in the present program. Without advocating a continuation of HIBAC as it has operated in recent years, the AAMC strongly recommends the maintenance of an advisory board to the Secretary of HEW of providers, practitioners, and consumers from the private sector which publicly advises the Secretary of the implementation of program changes.

Conclusion

In conclusion, the Association expresses its appreciation to the Committee for this opportunity to testify on S. 1470. The Association share the Committee's objective of improving the Medicare and Medicaid programs, and the Association has offered this testimony on the legislation as a sincere effort to refine and improve the proposed amendments.

Senator TALMADGE. The next witness is Michael D. Bromberg, director, national offices, Federation of American Hospitals, accompanied by Robert J. Samsel, president.

Mr. Bromberg, you may insert your statement in full in the record and summarize for 10 minutes.

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES, FEDERATION OF AMERICAN HOSPITALS, ACCOMPANIED BY ROBERT J. SAMSEL, PRESIDENT

Mr. BROMBERG. Thank you, Mr. Chairman. Accompanying me is Mr. Samsel, who, in addition to being our president, is vice president of American Medical International, one of the world's largest hospital management companies. Our association represents 1,050 hospitals with over 111,000 beds. In addition, our member hospital management companies now manage under contract over 165 additional hospitals, including teaching institutions, public, religious and other community nonprofit hospitals.

As taxpaying institutions, investor-owned hospitals have been particularly interested in modern professional management of our Nation's health facilities. S. 1470 recognizes the need to amend the medicare and medicaid programs in order to provide economic incentives for effective and efficient management systems in participating hospitals. We commend the subcommittee chairman for his leadership in proposing these meaningful incentives.

When medicare and medicaid were first enacted 11 years ago, and until quite recently, Congress perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision triggered the demand-pull inflation which is a major reason for these hearings.

Since Government has become the largest single purchaser of health care, the marketplace has become increasingly artificial as Government control over both the supply and demand intensifies.

The hospital industry has been hit with severe inflationary pressures for the past 10 years and in particular, following the expiration of the economic stabilization program in early 1974. Those major pressures included catchup wages in a labor-intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel, and malpractice insurance; a rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; the increased costs of borrowing capital; increased costs of compliance with Government regulations; and the medicare-medicare retrospective cost reimbursement formula which provides no incentives for efficient management and fails to meet its fair share of the total financial requirements of hospitals, forcing institutions to shift additional costs to private patients.

This combination of demand-pull and cost-push inflation has created a hospital industry with an annual inflation rate well above the national consumer price index.

HEW has identified three major causes for soaring inflation in the hospital sector of the health industry: unrestrained demand, lack of competition among facilities, and the current system of cost reimbursement. However, instead of addressing those underlying causes of inflation, the administration has opted for an arbitrary ceiling on revenues and capital. In its haste to solve within a few months a

budgetary problem which has been snowballing for 12 years, the administration has developed a scheme which exacerbates all that is wrong with the health care payment system.

There are other crucial issues which the administration plan impinges upon. It is a conflict of interest for government, as the major purchaser of health services, to unilaterally determine the price that it will pay for those services. Furthermore, the scheme, as proposed fails to acknowledge a number of unalterable factors which in large part predetermine hospital costs, and therefore, charges.

For example, hospitals have no legal authority to control such physician-directed, and revenue-determining, factors as length of stay, number of services, and the frequency of admissions.

Nor do we seek such control, because it must be left to the physician, under direction from peer and utilization review boards, to make such decisions. However, an arbitrary cap on revenues ignores physician, not hospital, authority in this area.

The revenue cap also fails to recognize that, minus a cap on the cost of supplies and services, hospitals would be forced to absorb such costs, to the detriment of the quality of care delivered. A ceiling on revenues is price controls on a single industry. It amounts to nothing more than a more stringent version of the phase IV hospital price control program rejected by a prior Congress for sound economic, social, and medical reasons which remain valid today.

In contrast with the administration proposal, the medicare-medicaid reimbursement reform bill reintroduced by Senator Talmadge, represents a major step forward in making these programs more cost efficient. It is an innovative, imaginative plan reflecting an examination of both cause and effect as a necessary adjunct to proposed solutions. The measure correctly presupposes that incentive-based competition—not self-defeating caps—is essential to alleviate escalating costs in the health sector.

We have a number of suggestions on pages 7 through 12 for minor amendments to section 2 of the bill. I will just mention one or two of them.

First, we believe that where a ceiling for reimbursement is imposed, a hospital should be allowed to charge the program beneficiary for the difference between the ceiling and actual costs. This is particularly important since the bill prohibits a shifting of those costs to private patients, and the hospital would have to absorb it otherwise. The rise in cost of care should be a matter of shared responsibility to all, and that includes stimulating public awareness through increased out-of-pocket public participation in the cost of care.

Someone has to pay for medicare and medicaid benefits.

Secondly, we would urge the committee to go very slow and exercise caution in delegating to the States the power to set rates for medicare. We believe that more time is needed to evaluate State ratesetting programs and the bill should be amended to provide that only those States that have 2-year experience in ratesetting prior to the enactment of the bill should be allowed a waiver.

In addition, we would urge that new hospitals less than 3 years old be placed in a special category, or made exempt, because of unusually high start-up costs.

On page 13 of our testimony we discuss the issue of rate of return, which is addressed in section 46 of the bill. We urge the committee to provide for a rate of return equal to industries of comparable risk. That, we believe, should be the test, rather than any single number.

A study was contracted for by us with ICF, Inc., a Washington-based consulting firm. The study was released this morning. I would like to leave a copy for insertion in the record, with the permission of the chairman.

Senator TALMADGE. Without objection, so ordered.

[The executive summary of the study referred to follows. The balance of the study was made a part of the official files of the committee.]

AN EVALUATION OF MEDICARE RETURN ON EQUITY PAYMENTS TO INVESTOR-OWNED HOSPITALS

Executive Summary

A. PURPOSE

The purpose of this study is to determine the rates of return on equity (ROEs) that the Medicare program should pay to investor-owned hospitals (IOHs) for services to Medicare patients. This report is intended to provide an analytical basis for evaluating changes in the present ROE payment formula under Medicare, and for identifying a range of average ROE levels that is appropriate under any type of reimbursement system, including incentive or prospective reimbursement systems.

This analysis assumes that Congress intended for the Medicare program to pay the full reasonable cost of equity capital, and that the cost of equity capital for IOHs is equivalent to the rate of return earned by investors in industries of comparable risk. The first assumption is based upon the regulations for the Medicare program, which state that:

"the share of the total institutional cost that is borne by the [Medicare] program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients,"¹ and

"an allowance of a reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services to beneficiaries by proprietary providers."²

Implicit in this assumption is the fact that certificate-of-need and Section 1122 capital disallowances, not Medicare ROE payments, represent the Congressionally-mandated approach by which unnecessary hospital investments are prevented. This approach is consistent with the need to ensure the availability of capital to maintain existing hospital investments and to make new investments where Health Systems Agencies authorize them. This approach also ensures that non-profit hospitals and investor-owned hospitals are treated evenhandedly, without regard to their tax status.

The second assumption is based upon the principles that have been established in federal rate-setting proceedings conducted by state public utility commissions and regulatory agencies such as the Federal Communications Commission. These principles, based primarily upon the 1944 Hope Natural Gas case,³ state that private businesses which employ their assets in service of the public interest should be paid rates of return which:

Protect their financial integrity;

Reward their investors at a level commensurate with the risks the investors assumed in making their investment; and,

Permit the companies to attract new capital for purposes of maintaining and expanding their operations.

These principles form the basis for determining appropriate rates of return in virtually every regulated industry, and, therefore, appear to be well-suited to the Medicare program.

¹ 20 C.F.R., § 405.402(a).

² 20 C.F.R., § 405.429(a).

³ *Federal Power Commission vs. Hope Natural Gas Company*, 320 U.S. 591 (1944).

B. APPROACH

The basic approach was to examine the financial characteristics of the investor-owned hospital industry and to compare the riskiness of IOHs with that of other consumer product and service industries. Using this comparison, we identified other industries of similar risk and established a range of appropriate rates of return on equity for IOHs for the years 1969 through 1975. A range was used rather than a single ROE because it is not possible to measure industry risk precisely.

In order to analyze IOH financial characteristics, we first compiled financial data on ten major hospital management companies whose financial statements are filed annually with the Securities and Exchange Commission. Those companies operate about 42 percent of all IOH beds and over 80 percent of the beds owned by hospital management companies. Hence, they represent a major portion of the IOH industry. In addition, although independent IOHs tend to be smaller, they seem to have risk and return characteristics which are similar to the larger hospital management companies in our sample. As a result, we are confident that our findings can be safely applied to investor-owned hospitals in general.

We next compared the financial data on these ten hospital management companies with similar information on 24 major consumer product and service industries. These comparisons focussed explicitly on the average returns earned by these industries over the 1969-75 period in relation to four measures of risk:

Variability of profit margins, which measures the uncertainty of the earnings in an industry and, thus, the exposure to demand or competitive factors which increase the risk to stockholders;

Financial leverage, which measures the proportion of an industry's capitalization that is financed by debt. Leverage reflects the risk assumed by stockholders because it indicates the extent to which lenders have a prior claim on assets when a default occurs,

Interest coverage, which measures financial risk in terms of the adequacy of firms' profits to cover their interest payments; and,

Stock price volatility (beta values), which indicates investors' overall perception of industry risk as reflected in movements of firm's stock price relative to the stock market average.

Based upon the analysis, we identified those industries which were definitely less risky than the IOH industry over the period to establish an appropriate lower limit on the range of ROEs that IOHs should have earned during 1969-75. Then, we identified industries of comparable risk over the period and used the ROEs earned by these industries as the basis for an appropriate upper limit on the ROEs that IOHs should have earned over the same period.

Using these ROE estimates, we examined how the present Medicare cost-reimbursement formula could be modified to provide appropriate rates of return. Specifically, we analyzed the impact of alternative Hospital Trust Fund multiplier values on Medicare ROEs over the 1969-75 period and evaluated the use of alternatives to the interest rate on bonds purchased by the Hospital Trust Fund.

C. FINDINGS AND CONCLUSIONS

1. *The IOH industry faces above average financial and business risk in comparison to other consumer product and service industries.*—Using measures of the variability of profit margins, financial leverage, interest coverage, and stock price volatility, we found that IOHs face risks which are viewed by investors and bankers to be similar to those of industries in the second highest quartile of risk (see Table 1 on page 7). These industries include broadcasters, brewers, shoe manufacturers, food processors, leisure industries and dairy products. Although some claim that providing care to Medicare patients entails less financial risk than providing care to private patients, we could find no support for that claim among those who provide capital to all types of hospitals.

2. *To achieve ROEs commensurate with this risk, the IOH industry should have earned rates of return on equity between 11 and 16 percent over the 1969-75 period.*—Average after-tax Medicare ROEs during this period ranged from 4.7 to 6.3 percent, and overall hospital ROEs averaged between 10.0 and 12.2 percent over these years. The Standard and Poor's 400-stock average over this period was 12.3 percent. Hence, IOH earnings were in the low range of appropriate ROEs for their

risk, and Medicare paid a substantially smaller share for equity costs than other hospital patients (see Table 2 on page 7). This share was even below the ROEs earned in low risk regulated industries such as electric utilities. Thus, non-Medicare patients subsidized the use of hospital services by Medicare patients to the extent of the difference.

3. *Under the Medicare ROE formula, return on equity payments should have been based upon a 3.7 Hospital Trust Fund multiplier rather than the current 1.5 multiplier.*—A multiplier equal to 3.7 would have yielded IOH rates of return on equity which were commensurate with their risk during each year of the 1969–75 period. If Medicare recognized taxes as an allowable cost, then the corresponding appropriate Trust Fund multiplier should have been 2.0. In 1976, the use of a multiplier of 3.7 would have increased total Medicare costs (net of taxes) by about \$28 million or less than 0.3 percent of total Medicare program costs.

4. *Medicare disallowances of certain unavoidable hospital expenses or investments can produce effective Medicare ROEs which are below the appropriate nominal rates identified above.*—Consequently, higher Hospital Trust Fund multipliers might be needed to ensure that effective ROEs are commensurate with the ROEs in similar risk industries. Such unavoidable costs disallowed by Medicare include income taxes, routine SEC registration costs, and other stock maintenance costs. If such disallowances represent three percent of total costs attributable to Medicare, then a Trust Fund multiplier equal to 5.1 rather than 3.7 would have been required to provide the appropriate average ROEs during 1969–75. Medicare equity disallowances include denial of fair market value assessments of IOH land used for hospital expansion and of hospitals acquired through the exchange of stock. When three percent of the value of such investments is disallowed by Medicare, then the Trust Fund multiplier needed to provide appropriate ROEs during 1969–75 would have been 3.8.

5. *Medicare ROE payments in the indicated range would allow IOHs to reduce non-Medicare patient charges by at least two percent, or reduce the amount of debt capital employed by some IOHs.*—By eliminating the current subsidy of Medicare patient expenses by other payors, hospital charges could be reduced on average by about two percent without reducing overall IOH profits. In areas where third-party cost-reimbursement covers a larger than average proportion of all patients, non-Medicare charges could be reduced even more. Alternatively, these ROE payments could permit IOHs to raise additional equity and thereby reduce some of the risk created by the use of large amounts of debt. The higher Medicare ROEs might thus tend to be offset by the lower interest rates and payments which result from a less risky capital structure. Under certain circumstances, this return to a more balanced capital structure would produce lower total capital costs.

6. *Under alternative Medicare reimbursement systems, IOHs should still receive ROEs which on average are consistent with the 11 to 16 percent returns.*—Although our analysis focussed specifically on changes under the present Medicare cost-reimbursement system, most experts agree that Medicare reimbursement should be reformed to promote greater efficiency among hospitals. If a different reimbursement approach is adopted through legislation or changes in DHEW policy, then the new approach should still provide a target average industry ROE of at least 11 to 16 percent, because the IOH industry continues to face the same business and financial risks as before. Indeed, a new reimbursement system could actually increase industry risk. This seems to have occurred in other regulated industries that are naturally competitive, such as airlines and nursing homes.

7. *Future analysis should focus upon three key factors which affect the determination of appropriate ROEs for investor-owned hospitals.*—Specifically, future work should focus upon:

The degree to which certain unallowable costs and investments are simply unavoidable in IOH operations and thus may unreasonably reduce the effective return on equity;

The potential impact on return on equity and capital structure of alternative Medicare reimbursement proposals; and,

The degree to which full payment of IOH debt costs and partial payment of equity costs affects total costs of capital and the resulting capital structure.

These factors are important in the establishment of an appropriate regulatory policy for hospital reimbursement and were simply beyond the scope of this study.

TABLE 1.—COMPARISON OF RISK IN THE IOH INDUSTRY WITH RISK IN 24 OTHER CONSUMER PRODUCT AND SERVICE INDUSTRIES, 1969-75

Quartiles	Financial leverage ¹	Variability in profit margin ²	Pretax interest coverage	Market price volatility (B)
Highest risk.....	3.15	83.8	3.0	1.40
Medium risk.....	2.14	15.9	7.1	1.19
Low risk.....	1.89	8.6	10.8	1.01
Very low risk.....	1.63	4.7	20.4	.85
Average.....	2.20	28.3	10.3	1.13
Hospitals.....	2.84	18.4	3.3	1.29

¹ Total assets divided by equity.² Standard deviation of profit margins divided by average profit margin.

Source: Tables 14, 15, 16, and 17 in ch. II.

TABLE 2.—ICF ESTIMATES OF APPROPRIATE ROE's FOR INVESTOR-OWNED HOSPITALS, 1969-75

[In percent]

Year:	Range of appropriate ROE's		Actual Medicare ROE's ¹	Actual IOH ROE's ¹
	Low	High		
1969.....	12.0	15.3	4.9	12.2
1970.....	10.4	16.5	5.5	11.2
1971.....	11.0	16.7	4.7	10.8
1972.....	11.7	17.1	4.9	10.5
1973.....	11.5	16.8	5.8	10.0
1974.....	10.6	16.8	6.2	10.0
1975.....	11.1	14.9	6.3	11.1
Average, 1969-75.....	11.2	16.3	13.8	10.8

¹ Sales-weighted average of 10 major hospital management companies.

Source: Tables 3 and 4 in ch. II.

Mr. BROMBERG. That study finds that the aftertax return on equity in comparable industries was 11 to 16 percent. The law has been interpreted to make our return on equity a pretax return. Under present law, we would only get 5 percent after taxes. As the bill is written, under section 46, that would be increased to 7 percent after tax.

We think the study will document the need for higher return.

I would like to make a comment on the administrative reforms of the bill. On page 22 of our testimony, in addition to the concerns that the chairman and others have expressed we have another one, and that is, that the quality of care may be subordinated to budgetary problems unless this new Health Care Financing Administration is either placed under the Assistant Secretary for Health or under a new Under Secretary for Health.

We do not think it is really possible to separate quality and cost issues. We are afraid that having one agency concerned with costs separated from the top position in the Department of HEW that those issues will not be properly addressed.

Finally, at the end of our testimony, starting at page 25, we make the following conclusions. This bill is a result of a great deal of well-thought-out labor on the part of the subcommittee chairman, the mem-

bers, and the committee staff. On its own, it may be considered to be a bill with a great deal of merit; compared to arbitrary cost control schemes, it is particularly commendable.

The impact of this bill, S. 1470, on reducing the rate of inflation in cost reimbursement under medicare and medicaid should automatically impact non-Government program costs. Charges to private patients, for example, should rise less sharply because actual costs will be moderated and will be rising at a much slower pace as a result of your bill.

For this reason, together with our opposition to any Government price controls over one industry, we urge you to limit application of your bill to medicare and medicaid. We will be very much willing to work with the staff to see how the bill can be applied to ancillaries. We would like to see the concept limited first to medicare and medicaid and with respect to other patients to make sure that there is no shifting of costs.

We would recommend use of a general jawboning policy particularly emphasizing public disclosure, rate review, and public finance. It seems to us that there is not enough disclosure in the hospital field. Not only do consumers not pay at the time they get the service, they make payments, but do not pay at the time they get it, but also they are not aware of what the competitive charges are.

It seems that the first step to stimulate the competition would be disclosure.

Second, the threat of adverse publicity, for example, from findings of local insurers or the President's Council on Wage-Price Stability in the cases of unjustifiably high rate increases, the threat of adverse publicity in itself would create a problem which most hospitals would attempt to hold down climate increases.

A national guideline for hospital price increases could be established, with review of such increases by the President's Council, utilizing publicity.

We commend the committee for taking the lead in changing the medicare and medicaid programs, and thank you for this opportunity to present our views.

Senator TALMADGE. Thank you, Mr. Bromberg, for your constructive testimony.

Do you have any questions, Senator Dole?

Senator DOLE. Just briefly. It is an excellent statement.

I asked the previous witness why does not the free market operate in the medical care arena and I just noted that you were sort of nodding your head. I could not get that in the record. I thought I would ask you the same question.

Mr. BROMBERG. Let me take a shot at it, Senator. I think, Senator, it has not worked because nobody has let it work. I think this bill, S. 1470, is the first effort I have really seen in the Congress to inject competition. I think competition can play a role.

I agree that hospitals are not like automobile companies, but there are certain analogies. We do not, for example, say that there should be a 9-percent limit on automobiles or food or housing, although people spend almost as much on food and housing as they do on health.

We do say if you want to buy a Cadillac instead of a Chevrolet you have that right. We are not going to take that away from you and

say that all cars should be no higher in quality than Chevrolet, but because the patient does not have that choice under the administration bill—it would just put a flat cap on that—that eliminates competition. By classifying hospitals by size and looking at the average costs, that is the classic way of stimulating competition: by rewarding efficiency.

Until we have more public disclosure, until we have more patient cost sharing, we cannot have true competition in that sense.

Senator DOLE. That is the point I wanted to make. Only 10 percent of the costs now are paid by the patient, is that correct?

Mr. BROMBERG. Yes; that is correct. Third party payers not only pay them, but the patient never even knows about it. Although he pays the premium, he pays that premium at the beginning of the month. He does not pay it when he sees the doctor or goes to the hospital. That is another problem, paying at the time that the service is received.

We realize that there are people who cannot afford it, that to the medicaid patient, the first dollar coverage may be catastrophic. To the vast number of other Americans, that is not true. It does not have to be applied that way.

Senator DOLE. I do not know how the insurance companies work. Maybe I can find out. It seems like they should be exercising a cost-conscious discipline when they decide what rates to pay and what premiums to charge. Maybe they do, but it must not be very tough.

Mr. SAMSEL. They should be considering what benefits should be offered to the public as well—what benefits, possibly that the beneficiary should be paying the first dollar.

Senator DOLE. One way to bring about efficiency, when I start paying more, I take a closer look at it.

Mr. BROMBERG. When you have cost reimbursement, we will pay you whatever you spend. There is no way you can stimulate competition or efficiency. The more you spend, the more you get.

The other point I would like to make, you asked the question of a prior witness as to whether there were any fat hospitals in their association. Under the administration bill, the fat hospitals would get fatter.

The problem is even more compounded.

Senator DOLE. I suggested it would be the survival of the fattest. I guess that would fit the administration's program.

Finally, there has been a consensus or a feeling among those who testified that perhaps the bill introduced by the chairman and others should be expanded to cover all payors.

You do not feel that this would be satisfactory, or workable, or necessary?

Mr. SAMSEL. I do not feel it should be extended at this time. The extension to other fields, such as the third party payors, direct payment, robs the management again of his essential management techniques at arriving at the appropriate price levels he should be charging for services.

We do not believe that the outside bureaucratic influences can really come to the appropriate price levels. They should be charged for an individual hospital. We are talking about very complex organizations. Many things have to be taken into account. We are utilizing very good management techniques to arrive at those various areas

that are necessary to address in setting rates. We do not believe that they can be ascertained from outside the hospital itself. I do not think Government establishing the price level is only a temporary measure and it really takes away from the manager his ability to be efficient in the long run.

Mr. BROMBERG. Taking it across the board would, in effect, do to the hospitals what the Health Security Act does to the whole health system. It places in the hands of the Federal Government total control over an industry, in this case, part of an industry, hospitals.

I think it is that objection to price controls, as well as the fact that until we see how it works under medicare and medicaid, we would be making a dramatic jump, that leads us to that conclusion.

Mr. SAMSEL. You would be greatly surprised what incentives would do for the efficient management of hospitals.

Senator DOLE. I am certain they are significant. Are the investor-owned operations costs less?

Mr. BROMBERG. Last year we paid \$50 million in property taxes and \$150 million in income taxes, so we are a taxpaying industry as well. We like to think our rates are very competitive.

One other point—it came up yesterday, and I would like to address it briefly. Secretary Califano has made several comments over the past 2 weeks about one example of the fact that hospitals could cut is the \$1 billion in profits that exist. I would like to point out for the record, as I have to him in a letter last night, \$1 billion surplus from 7,000 hospitals, 6,000 of which are nonprofit, \$1 billion surplus on \$55 billion in revenues is less than a 2-percent margin which I think is not only low, but dangerously low.

Our particular industry is a for-profit industry. We had \$250 million profits on \$5 billion in revenue, or 5 percent. When compared to any other sector or any other industry, any other sector of the health field, certainly when compared to hospital supply companies, that is dramatically low. If the quality of just existing plant and services is to be maintained, I think a 2-percent reserve should not be used as an example of where costs need to be cut. It shows a misunderstanding, I think.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, gentlemen, for your very constructive and very helpful testimony.

[The prepared statement of Mr. Bromberg follows:]

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES, AND ROBERT J. SAMSEL, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

On behalf of the members of the Federation of American Hospitals, we would like to thank the Committee for this opportunity to present our views on proposed reforms of the Medicare and Medicaid programs.

I am Michael D. Bromberg, Director, National Offices of the Federation. Accompanying me is Robert J. Samsel, President of our organization and Vice President of American Medical International, Inc., one of the world's largest hospital management companies.

The Federation of American Hospitals is the national association of investor-owned hospitals, an industry with 1,050 hospitals in the United States and over 111,000 beds. In addition, our member hospital management companies now manage under contract over 165 additional hospitals, including teaching institutions, public, religious and other community non-profit hospitals.

As tax paying institutions, investor-owned hospitals have been particularly interested in modern professional management of our nation's health facilities. S. 1470 recognizes the need to amend the Medicare and Medicaid programs in order to provide economic incentives for effective and efficient management systems in participating hospitals. We commend the Subcommittee Chairman for his leadership in proposing these meaningful incentives.

RIISING COSTS

When Medicare and Medicaid were first enacted eleven years ago, and until quite recently, Congress perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision triggered the demand-pull inflation which is a major reason for these hearings.

Since government has become the largest single purchaser of health care, the marketplace has become increasingly artificial as government control over both the supply and demand intensifies.

The hospital industry has been hit with severe inflationary pressures for the past ten years and in particular, following the expiration of the Economic Stabilization Program in early 1974. Those major pressures included catch-up wages in a labor intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel and malpractice insurance; a rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; the increased costs of borrowing capital; increased costs of compliance with government regulations; and the Medicare-Medicaid retrospective cost reimbursement formula which provides no incentives for efficient management and fails to meet its fair share of the total financial requirements of hospitals, forcing institutions to shift additional costs to private patients.

This combination of demand-pull and costpush inflation has created a hospital industry with an annual inflation rate well above the overall consumer price index.

HEW has identified three major causes for soaring inflation in the hospital sector of the health industry: unrestrained demand, lack of competition among facilities, and the current system of cost reimbursement. However, instead of addressing those underlying causes of inflation, the Administration has opted for an arbitrary ceiling on revenues and capital. In its haste to solve within a few months a budgetary problem which has been snowballing for twelve years, the Administration has developed a scheme which exacerbates all that is wrong with the health care payment system.

There are other crucial issues which the Administration plan impinges upon. It is a conflict of interest for government, as the major purchaser of health services, to unilaterally determine the price that it will pay for those services. Further more, the scheme, as proposed, fails to acknowledge a number of unalterable factors which in large part predetermine hospital costs, and therefore, charges. For example, hospitals have no legal authority to control such physician directed (and revenue determining) factors as length of stay, number of services, and the frequency of admissions. Nor do we seek such control, because it must be left to the physician (under direction from peer and utilization review boards) to make such decisions. However, an arbitrary cap on revenues ignores physician, not hospital, authority in this area.

The revenue cap also fails to recognize that minus a cap on the cost of supplies and services, hospitals would be forced to absorb such costs, to the detriment of the quality of care delivered. A ceiling on revenues is price controls on a single industry. It amounts to nothing more than a more stringent version of the Phase IV hospital price control program rejected by a prior Congress for sound economic, social, and medical reasons which remain valid today.

S. 1470

In contrast with the Administration proposal, the Medicare-Medicaid Reimbursement Reform bill re-introduced by Senator Talmadge, represents a major step forward in making those programs more cost efficient. It is an innovative, imaginative plan reflecting an examination of both cause and effect as a necessary adjunct to proposed solutions. The measure correctly presupposes

that incentive-based competition—not self-defeating caps—is essential to alleviate escalating costs in the health sector.

INCENTIVE REIMBURSEMENT

We realize that much of the impetus for reform of Medicare-Medicaid stems from increasing Congressional insistence that these programs operate in a manner that is as cost efficient as possible. Replacement of the current, highly inflationary system of retrospective payment would be our primary recommendation for reforming institutional reimbursement.

The Federation of American Hospitals has long favored increased experimentation with prospective payments for hospital services based on negotiated rates or target rates established by a formula. Our association favors a major overhaul of the Medicare-Medicaid reimbursement system for institutional providers; however, we also believe that experimentation on a national basis involving several prospective payment methods is necessary to determine appropriate long range systems.

We generally support the determination of a target rate for routine operating costs as outlined in Section 2 of S. 1470, with the following suggested revisions:

We endorse the general approach of Section 2 which includes economic rewards for efficiency. By establishing a target based on average routine costs, the proposal, as already noted, seeks to inject competition among similar facilities.

The incentive feature of Section 2 should be amended so that the bonus payment is not restricted to 5% of the average routine operating costs. Instead, hospitals whose costs are below the target should be reimbursed for actual costs plus one-half the difference between their costs and the average for their category. Thus a hospital whose costs are \$80 per day as opposed to a \$100 group average, would receive a bonus payment of \$10, rather than \$5. We believe that the 5% limit lessens the potential impact of the program and can be deleted without impairing its overall cost effectiveness. Barring this, we recommend that the incentive features of Section 2 be broadened to provide for provider retention of savings of up to 7½% of the first \$100 of routine operating costs and up to 5% of any excess. This would place even greater emphasis on efficiency by reducing the reward for high cost institutions compared to lower cost facilities. A sliding scale for incentive payments is more equitable because it would make the dollar rewards more uniform for all hospitals.

The legislation provides for an adjustment to the average per diem routine cost for area wage differentials. This is a most important adjustment since payroll costs represent about 55% of total hospital costs. We recommend that the bill be clarified by including a definition of the word area to assure that the adjustment is made for community differentials within states.

The restrictions on reimbursement for those hospitals with routine costs more than 20% above the group average should be more flexible. The exception procedure should assure that no institution is penalized for costs beyond its control. Inefficiency should be penalized but unforeseen or uncontrollable events should be defined and recognized as justifiable causes for cost increases.

Where the restrictions on reimbursement are imposed, the facility should be allowed to charge the program beneficiary for the difference between the reimbursement ceiling and its actual costs. This is particularly important since the bill stipulates that hospitals may not increase their rates to other payors in order to offset Medicare and Medicaid reductions resulting from implementation of the legislation. Without such relief, hospitals would be forced to absorb these extra costs. The rising cost of health care should be a matter of concern—and shared responsibility—to all of us. That includes stimulating public awareness through increased out-of-pocket expenses, and government recognition that someone must pay for increased Medicare-Medicaid benefits.

A major change in this year's bill would exempt from the proposed reimbursement system those states which have effective rate setting agencies with authority over all classes of purchasers. The bill requires that the state program results in lower aggregate Medicare and Medicaid costs than would otherwise be incurred.

An evaluation of the long-range efficacy of such an approach has yet to be completed. In hearings before the Ways and Means Health Subcommittee last

year, an HEW representative acknowledged that it would be at least three more years before the effectiveness could be gauged. We would, therefore, recommend that this exemption for state programs be deleted. If an exemption for state programs is provided, we recommend that only those states with a minimum of two years of experience in rate review prior to enactment of S. 1470 be considered for an exemption. At least that much time would be required to establish a workable system generating sufficient data for the Secretary to review.

Furthermore, the test should not be whether or not the state system results in lower Medicare and Medicaid costs alone, but if the system is expected to result in a long-range reduction in the total cost increases of all classes of purchasers. Otherwise there is an incentive for states to mandate further discounted rates for government subsidized programs, with hospitals forced to absorb the difference.

With regard to the method for determining a group average, we believe that as this average decreases over time due to the incentives incorporated in the bill, it may become too harsh. Ultimately, more and more hospitals could be penalized. To prevent this, we recommend that two years after the program is in place the target per diem be based on the average plus 10%.

Turning to suggested modifications in the exceptions procedures, we would like to recommend that there be an exemption for new hospitals built with required planning approval to recognize the high start up costs as well as higher debt services of a new facility or wing. This exemption is needed because of initially low occupancy rates that push up the average per diem costs of new facilities making it unfair to expect those hospitals to compete with already established facilities. We recommend that new facilities be exempt from the target rate for their first full three fiscal years.

For similar reasons we suggest an exception for sudden and uncontrollable drops in occupancy in an established facility. The Economic Stabilization Program provided such an exception for reductions in occupancy of more than 5%.

Another concern is that recognition needs to be given to differences in treatment modality for psychiatric facilities. The legislation should require the Secretary to take into account the treatment modality of psychiatric hospitals and give recognition to the variation in personnel needs demanded by the different programs.

For example, a psychiatric hospital that has extensive shock treatment modality will have a very different pattern of personnel requirements than a psychiatric facility that has programs which have milieu therapy treatment. Yet these are all accepted and recognized treatment modalities for mental health care.

We urge the Subcommittee to recommend a "hardship" exception for other "unforeseen and uncontrollable" events which cause significant cost increases.

Finally, S. 1470 requires that the Secretary, by a given date, establish "an accounting and uniform functional cost reporting system." Although we assume that this means development of a system of uniform reporting only, we would like to see that language so clarified. The requisite data can be obtained through a uniform reporting system bolstered by uniform definitions of reported costs without imposing a costly and burdensome system of uniform accounting.

CONTINUED EXPERIMENTATION

We believe that the performance-based reimbursement system outlined in S. 1470 represents a major step in making Medicare and Medicaid more cost efficient. However, it is essentially not a system of prospective rates. We believe that if payments are to be closely related to actual costs, they should be made on a predetermined basis. Therefore, although we favor the implementation of the target rate scheme proposed in S. 1470, we recommend that the Secretary be directed to engage in an intensive program of experimentation along prospective lines. Experimentation on a national basis involving several prospective rate methods is necessary to determine appropriate long range systems.

It is important to understand that because Medicare has not paid its fair share of institutional costs for providing services to program beneficiaries, health facilities have been forced to increase charges to non-government patients. The inflationary impact of Medicare has been felt throughout the health field. By changing the payment system to a predetermined rate, we can begin to reduce the annual inflation rate, but the Medicare program must first acknowledge its obli-

gation to pay a fair rate for services rendered. There will, therefore, be no federal budgetary savings in the initial periods of experimentation with prospective rates. There should, however, be an immediate impact on inflation rates in charges to non-government patients as well as long range cost containment for the Medicare program.

The concept of a predetermined rate for specific treatments on a per diem or per admission basis by diagnosis is one example of the type of prospective rate system we believe should be developed and tested. Other examples include a negotiated rate; a negotiated discount from billed charges with a negotiated inflation rate for subsequent years; and a rate review process limited to facilities whose rates exceed a percentile of group charges or costs.

RATE OF RETURN

We urge the Committee to amend the Medicare law to create a mechanism for the annual determination of a reasonable rate of return on investment. The Medicare rate of return should be equal to investments of comparable risk in other industries.

An adequate rate of return is necessary for a number of reasons, most importantly to: (1) protect the hospital's financial integrity and maintain its credit; (2) to reward investors at a level commensurate with the risk assumed in making their investment; and (3) to attract new capital for maintenance and needed expansion.

In no other industry are income taxes not recognized as an operating expense for purposes of cost based reimbursement or rate of return. By eliminating income taxes as a reimbursable cost, the Department of HEW has effectively reduced the return on equity for investor-owned hospitals to approximately 10% on a pre-tax basis or an after-tax return of approximately 5%.

Investor-owned hospitals must make a fair return on investment in order to be viable, and if the federal government refuses to pay its fair share, this increases the return needed from the private patients, in order to make the overall return acceptable. This is, in effect, an indirect subsidy to the federal government at the expense to private patients needing hospitalization. Such cross-subsidization represents not only a direct violation of the Medicare law, but is a major cause of inflation in the private sector of the health industry.

Last year, in a case filed in the U.S. District Court for the District of Columbia, *Humana of South Carolina, Inc. v. Mathews*, Civil Action No. 75-0302, the court ruled that the Secretary of HEW must establish new guidelines for the determination of an appropriate rate of return on equity capital for investor-owned hospitals participating in the Medicare program. Humana contended that the current formula of one and one-half times the trust fund yield does not reimburse the reasonable cost of providing services insofar as a return on equity capital is such a cost and therefore, hospitals are forced to raise their charges to private paying patients. The court held that such cross-subsidization directly violates 42 U.S.C. § 1395x(v)(1)(A), the law governing the Medicare program. The court directed the Secretary of HEW to make "a detailed study of the various factors affecting the economics of the proprietary hospital industry" in order to enable the Secretary to determine the actual level of return needed to provide a reasonable return on equity and avoid cross-subsidization.

The Federal Power Commission, the Civil Aeronautics Board, the Federal Maritime Commission, the Interstate Commerce Commission and the Federal Communications Commission all recognize that federal income taxes represent a proper service cost in determining a just and reasonable rate of return.

Although S. 1470 attempts to correct this inequity by raising the allowable return to twice the rate on current hospital insurance trust fund investments until 1981 when it returns to the current 1½ times, we believe that this is still insufficient. Section 46 would in effect increase the rate of return from 5% after taxes to 7% after taxes. That proposed increase would still fail to make the rate of return equal to investment of comparable risk.

The Federation recently contracted with ICF, Inc., a Washington based consulting firm, for an in-depth study of rates of return on equity in industries comparable to the investor-owned hospital industry. The study has just been completed and copies will be furnished to the Committee Members and staff.

The summary of findings by ICF includes the following conclusions:

1. For comparable risk industries, the estimated range of an after tax return on equity was between 11.0% and 16.0%.

2. For investor-owned hospitals, this range implies a multiplier of 3.7 of the Hospital Insurance Trust Fund rate, rather than the 2.0 in the proposed legislation.

3. Depending upon the level of Medicare cost adjustments which represent necessary costs of doing business but unallowable by Medicare, the multiplier required to achieve reasonable returns for investors would be between 5.2 and 8.6.

We urge you to consider these alternative approaches to improve the current Medicare rate of return on investment:

(1) Provide for an annual determination by the Secretary of a return equal to rates of return on investments in industries of comparable risk;

(2) Recognize income taxes as an allowable cost of doing business, reimbursable under Title XVIII; or

(3) Increase the current formula to at least 3.7 times the trust fund yield.

CAPITAL EXPENDITURES

Section 4 of S. 1470 provides that Medicare and Medicaid reimbursement of both capital and direct operating costs would be prohibited when a capital expenditure has not met with specific approval. We support this as a valid means of strengthening the health planning law in a manner which will effectively restrain increasing costs. We believe that it should be up to individual HSAs, working to meet the needs of the communities they oversee, to decide what new capital expenditures are justified. This is in marked contrast to the Administration's proposed dollar ceiling on capital expenditures on a state wide basis according to population, coupled with a fixed ratio of four beds per 1,000 individuals or occupancy of 80%.

We do not, however, support the provision in S. 1470 which requires unanimous approval of a proposed capital expenditure when it involves an SMSA which crosses state boundaries. Although the other jurisdictions should certainly be actively consulted, the decision regarding approval should ultimately be left to the state in which the proposed expenditure will actually be made. That HSA should be equipped with sufficient data to accurately gauge the need—based on current and projected utilization trends—of the proposed project. It would be too cumbersome a process for approval to be secured from secondary jurisdictions and political stalemates could jeopardize needed health expenditures.

Finally we recommend an amendment requiring certificate of need agencies to solicit competitive applications for needed services, equipment, and facilities to stimulate competition and lower costs.

CONVERSION ALLOWANCE

The Federation supports that provision of the bill which encourages closing or converting underutilized beds or services by including in the hospital reasonable cost payment, reimbursement for costs associated with closure or conversion. However, in the case of for-profit hospitals, only increased operating costs would be recognized; capital costs would be disallowed.

We believe that regardless of ownership, hospitals should have both their capital and increased operating costs associated with closure or conversion recognized. To differentiate on the basis of ownership raises serious constitutional questions. If there are two hospitals located in a community—one a non-profit the other investor-owned—and the community believes that the investor-owned facility should be closed or converted to another use, the provision as presently stated provides no incentive for the investor-owned hospital to acquiesce. After all, no facility can be expected to shut down and retire its debt without benefit of patient income. The question should be "What is best for the community?" Then all costs connected with closing or converting the facility—regardless of ownership—should be recognized.

This provision is essentially experimental, limiting transitional allowances to only fifty hospitals per year for the first two years of operation. The Secretary would review all recommendations forwarded by the Hospital Transitional Allowance Board; however, there would be no appeal to the Secretary's final decision. We recommend that when the program becomes more than experimental, these decisions become subject to judicial review.

In addition, we recommend that total hospital closures be given priority under this voluntary program. Little or no dollar savings will be realized from closing some beds within an institution, but significant savings can be realized if an entire facility is purchased for fair value and closed.

HOSPITAL BASED PHYSICIAN REIMBURSEMENT

Insofar as control of physician reimbursement is concerned, we can understand the desire to discourage potential abuse or excessive payments by limiting the reimbursement for certain hospital based physicians. However, we believe that the actual method of payment—be it fixed fee, or percentage, lease, or direct billing arrangements—should be left to the discretion of hospital management. By restricting payments to a fixed fee, many rural areas might be unable to attract the services of these specialists.

We would not, however, be opposed to screens being applied to the final result of the hospital physician negotiations using a technique similar to the 75th percentile of the prevailing payment levels in the area.

Finally, there should be a "grandfather" clause covering all contracts made prior to enactment of S. 1470 between hospitals and hospital based physicians.

HOSPITAL CONTRACTS

We are pleased to note that Section 40 has been modified substantially, deleting last year's requirement that all contracts of \$10,000 or more be approved in advance by the Secretary. This modification reflects an awareness of the chaos that such a provision would have caused in the daily administration of a facility.

However, Section 40 still provides that no cost or charge will be considered reasonable for purposes of reimbursement under Titles XVIII or XIX if it represents a commission or finder's fee or an amount payable under rental or lease arrangement where payment is based on a percentage arrangement. The Federation objects to this provision which covers consulting and management contracts for the same reasons it rejects the restrictions imposed on contracts with hospital based physicians. We believe that these are matters properly left to the discretion of the hospital's administrator and Board of Trustees.

Section 2 of the bill precludes the need for the kind of line-by-line budget examination proposed in Section 40. Under the proposed target rate, the concern is properly with the total costs, not with all the individual components that go into that final figure. Hospitals are given incentives to come in under the target rate, or at the very least make sure that their per diem routine operating costs do not exceed 120% of the average rate determined for their category. This factor in itself serves to prohibit the negotiation of contracts that are excessive. We, therefore, recommend that Section 40 be deleted altogether from S. 1470.

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

We believe that the stated purpose of Section 20 of S. 1470—to make better and more flexible use of underutilized hospital beds in rural areas by permitting their conversion to long-term care beds with appropriate reimbursement—is an excellent one. We would suggest, however, that this provision be amended to delete the requirement that limits the section to hospitals with less than fifty beds. Since a certificate of need would be required prior to conversion, planning authorities would not be faced with a surplus of long-term care beds. Therefore, we do not think that the potential success of this provision should be blunted by the currently suggested fifty bed limitation.

ADMINISTRATIVE REFORMS

Turning lastly to the area of administrative reforms, the Federation shares Senator Talmadge's concern that the new Health Care Financing Administration may be guilty of furthering, rather than alleviating, the bureaucratic superstructure controlling the health sector.

We would suggest that in re-examining the purpose and proposed organization of such an Administration under Section 30 of S. 1470, that consideration be given to placing it under the direct supervision of the Assistant Secretary for Health or creating an Under Secretary for Health, rather than an Assistant Secretary for Health Care Financing. With the exception of the Secretary himself, the Assistant Secretary—or Under Secretary—for Health, should be the top spokesman and policy maker for departmental health policy. The position of Assistant Secretary for Health Care Financing could serve to undermine this authority.

In addition to weakening the basic powers of the Assistant Secretary for Health, establishment of an Assistant Secretary for Health Care Financing separates cost and quality issues, and places even more authority in the hands of health economists. We, too, support cost-consciousness, but we are concerned by the increasing preoccupation with budget that has come to characterize departmental thinking and regulation. Issues of cost and quality of care are appropriately addressed jointly. For this reason, we believe that the Assistant Secretary for Health should have jurisdiction over the new agency.

SIXTY DAY COMMENT PERIOD

With few exceptions, a thirty day comment period is presently provided for public comment on proposed regulations. In order to assure that regulations affecting health care are representative of sound public policy, it is mandatory that the public and the health sector as a whole be given the time to respond with comments and constructive recommendations. However, as matters now stand, by the time that the proposed regulations reach our hospitals, particularly those in western regions, we are left with considerably less than thirty days in which to evaluate regulations that are often complex and lengthy. There is often not sufficient time available to study the regulations, gather information on their possible and probable effect, and then formulate and forward a response to the Department of Health, Education, and Welfare officials. Therefore, we strongly support the provision to extend the period for public comment on proposed regulations to sixty days except in those cases where the urgent nature of the regulations demands otherwise.

HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The effective administration of Title XVIII depends in part on the cooperation—not confrontation—between government and the health industry. HIBAC was created by Congress when Medicare was first passed as a means for affirming Congressional intent that industry advice and cooperation be sought by the department. Instead of abolishing HIBAC, as proposed in S. 1470, we recommend that the Council's role in the regulatory process be clarified and where appropriate, broadened.

We recommend that HIBAC be reconstituted as a ten member advisory body, broadly representative of health providers, consumers, and third party payors, a more workable size than the present nineteen members. HIBAC should be an advisory body of the legislative as well as the executive branch. It should meet more frequently and all proposed regulations under Title XVIII should be submitted to HIBAC thirty days prior to initial publication in the FEDERAL REGISTER. Any regulation which HIBAC determines to be contrary to the public interest or inconsistent with sound administration of the Medicare program, should be reconsidered by the Secretary prior to initial publication.

These recommendations, if adopted, would help restore confidence and trust in the system by assuring a real dialogue between the payor and provider of program benefits.

CONCLUSION

S. 1470 is the result of a great deal of well thought out labor on the part of the Subcommittee Chairman, the Members, and the Committee staff. On its own it may be considered a bill with a great deal of merit; compared to arbitrary cost control schemes, it is particularly commendable.

These attempts to place arbitrary limits on hospital revenues ignore the causes of rising health costs, and fail to provide incentives to counter this trend.

The impact of S. 1470 on reducing the rate of inflation in cost reimbursement under Medicare and Medicaid should automatically impact non-government program costs. Charges to private patients, for example, should rise less sharply because actual costs will be rising at a slower pace.

For this reason, together with our opposition to any government price controls over a single industry, we urge you to limit application of S. 1470 to government programs.

With regard to non-government patients, we recommend use of the President's general economic policy of jawboning to hospital rate increases in excess of an

agreed upon percentage. The threat of adverse publicity from findings of local insurers and the President's Council on Wage-Price Stability would certainly create a climate in which most hospitals would attempt to hold down spending increases.

For example, all hospitals seeking charge increases in excess of 80% of the hospital service charge component of the CPI could be required to disclose and justify their budgets to their local Blue Cross plan and commercial insurance companies.

A national guideline for hospital price increases could be established with review of increases above that level by the President's Council on Wage-Price Stability, utilizing publicity as a disincentive to unrestrained price increases.

We commend the Committee for taking the lead in revitalizing and reforming Titles XVIII and XIX of the Social Security Act, and thank you for this opportunity to present our views.

Senator TALMADGE. Our next witness is Mr. John F. Horthy, president, National Council of Community Hospitals.

You may insert your statement in full in the record and summarize it in 10 minutes, if you will.

STATEMENT OF JOHN F. HORTHY, PRESIDENT, NATIONAL COUNCIL OF COMMUNITY HOSPITALS, ACCOMPANIED BY JOHN HUFF, COUNSEL

Mr. HORTHY. Thank you, Mr. Chairman, for the opportunity to appear here this morning. I have with me Mr. John Huff, legal counsel for the National Council of Community Hospitals. I will not read our statement to you, but rather attempt to summarize what we have said in our prepared statement, which we ask to be inserted in the record.

We have taken the position that the approach taken by this committee is a very constructive approach in an attempt to enact and formulate long-term reform in the health care system and we would welcome working with the committee in this effort. We do, however, urge the committee to consider postponement of the enactment of this kind of long-term reform because of our feeling that the present situation with respect to hospital costs is one which requires drastic action and also one which requires us to examine not merely the inequities in the present system, but also the possibility of total reform of the entire concept of the way in which hospitals are paid for their services. Not only the way in which hospitals are paid, but the way in which all sectors of the health care field are paid, physicians, and others.

In fact, it is our belief that the philosophy of reasonable cost reimbursement as such no longer provides the kind of incentives that this field needs, and therefore that the very excellently conceived and stated reforms of this bill would find the reasonable cost reimbursement systems do not get at the root problems of the entire industry at this point in time.

We therefore, in a sense, join with the administration in their concern with the immediate cost problem in the hospital field. However, as other witnesses have stated, we do not believe that the vehicle that the administration has adopted is a satisfactory vehicle. We have stated so in our testimony in detail. I will not go back over the litany of reasons that other witnesses have provided and which the committee already understands.

It is our belief that another action is necessary and we have proposed that action in our prepared testimony and propose it now. What we are suggesting is that this committee consider a freeze on hospital capital construction, on capital construction in this entire field—that includes nursing homes, governmental hospitals, and doctors offices, for not only equipment and facilities but across the board for 24 months.

That the committee also consider a freeze on full-time equivalents per patient day which would, in effect, have a dampening effect upon the rise of the intensity of services in the hospital field.

Several other proposals are a part of this package which we have made. We stated in our testimony that we ask that this freeze be applied for 24 months. The purpose of, the limitation that the freeze would end at the end of 24 months, is to use that period of time to consider real long-term and radical reform of the entire system, including the possibility of building in meaningful free enterprise incentives into the structure of payment, not into the structure of "reimbursement," a term which, in itself, characterizes certain philosophical concepts that perhaps are outmoded.

I think that the bill that you are considering today is one of the alternative methods of reforming the system. We would like to see it go much further than it does. We would be happy to provide technical amendments and changes and to work with the subcommittee and its staff, but it is our feeling at present that it is time to not only call a halt to what is going on, but to do so in such a manner that gets the issues out on the table—that is, to determine whether in fact the American public wants a growth system in this field; whether the American public wants a no-growth system.

The hospitals, I believe, have been unfairly accused of fostering unlimited and unrestrained growth. It may well be that that is precisely what the American public desires and that the trustees and other members of hospital boards and members of the hospital management and leadership are doing precisely what the country wants, or that may not be so. Let's see!

If the country wants a very modified or no-growth industry, it is my view that the hospital trustees and administrators could provide that service as well, without any new or increased intensity or increased services.

In short, Mr. Chairman, what we ask is a consideration of a very tough concept of going beyond the reasonable cost reimbursement system that was put in place 10 years ago for medicare and medicaid, and really looking at what other possibilities there are.

In that regard, I would like to make one or two statements with respect to the testimony that the Secretary of HEW made yesterday. I believe for the record there should be a couple of comments made with respect to his so-called fat list which unfortunately, because of the term, tends to excite media interest, which the actual facts do not justify. The \$1 billion profits which the Secretary characterized, involves the entire hospital industry; not as the Secretary implied, solely to nonprofit community hospitals, whom I represent; I think the Secretary's discussion of profit deserves response.

In the first place, generating a cash surplus is a traditional way of raising capital in this field. It has been used traditionally and the hospital boards have a tendency, in many instances, to practice pay as you go plans, despite the availability of easy loans capital over the past 10 years in this field.

I think, it is not imprudent to have accumulated these kinds of surpluses, it is eminently prudent to have done so.

I think the characterization of surpluses of \$1 billion in the community hospital field and \$250 billion pay-out of this \$1 billion in the profitmaking field amply puts the situation into perspective. One is not unreasonable, compared to the other.

It seems to me to cut out this surplus, to get your savings, as the administration suggests, out of this kind of money, is likely to convert community hospitals into welfare hospitals.

It seems to me that the Secretary already has sufficient problems with welfare reform without moving the hospitals into that category.

Secondly, questions of unnecessary therapy, unnecessary surgery. unnecessary hospitalization has been stated again and again by the Secretary in testimony and in the media. This is a very serious charge. If, in fact, there is this much, an awful lot of patients ought to be suing doctors, not hospitals, because hospitals do not admit them and do not order the therapy and should not be blamed. I do not believe that there are facts to support these charges.

It is very difficult, obviously, to prove this type of thing. I just do not believe that 100,000 patients are in hospitals at this very minute unnecessarily, as the Secretary states. Hospitals do not order therapy, do not give therapy. I think it is unfortunate to state that hospitals somehow force physicians to raise hospital charges by this kind of unnecessary practice.

It will come as a very grave shock to the dedicated trustees in 3,000 community hospitals around this country to know that what the Secretary charges is a widespread practice. I do not believe it is.

I think that the same is true of hospital's wasting energy. If ever there is a place that businessmen on hospital boards would attempt to save money, this is an area where they would move as rapidly as anybody else including HEW. I question whether the savings are as easy, as facile as the Secretary states.

Senator TALMADGE. How many hospitals does your organization represent, Mr. Horthy?

Mr. HORTY. Fifty hospitals scattered in 21 States, all of them community hospitals—one of them a very fine institution in the State of Georgia, Memorial Medical Center in Savannah.

Senator TALMADGE. It is very fine.

Your freeze on employment is an interesting one in view of your criticism of the administration's 9-percent cap as being inequitable.

Mr. HORTY. Yes.

Senator TALMADGE. Would not a freeze on employment also be inequitable inasmuch as the efficiently staffed hospitals would go along with the inefficiently staffed hospitals?

Mr. HORTY. No. Our membership which—I should expand somewhat on what I said—includes hospitals that range from 700 beds

such as the hospital in New Orleans down to very small hospitals. In fact, our membership has been chosen for this kind of a range.

We have consulted with each one of them. The freeze that we propose, is not a freeze on employment per se. It is a freeze on something that the technicians and comptrollers tell me is full-time equivalents per patient day.

That would mean, if utilization goes up, the full-time equivalents goes down, if the patient days go down, the full-time equivalents will go down.

The purpose of this is not a flat freeze. It is a restraint on increase and as such we believe it rightly places the burden upon the individual hospital, upon its management without mandating the wrong kind of decisionmaking.

It is not, for example, we make no bones—it does not prevent you from replacing a \$3 full-time equivalent with a \$10 an hour full-time equivalent. We believe the management of hospitals in this country is not likely to run wild in that kind of an environment because they have not up to the present. Hospital wages have not climbed over the past decade, or 20 years, in such a way as to indicate that hospital management or boards of trustees will take the easy way out on the business operations of their hospitals.

I do not believe that would happen under such a freeze. There is no attempt to freeze actual employment and we would be opposed to doing so.

Senator TALMADGE. Do you think Memorial Hospital would be agreeable to a 2-year freeze on employment?

Mr. HORRY. As expressed in the testimony, they would and have endorsed it.

Senator TALMADGE. Thank you.

Senator Dole?

Senator DOLE. I do not think that is going to happen. Based on that, what would you support?

Mr. HORRY. I support our proposal and we believe it may be enacted.

Senator DOLE. If it does not, you are not supporting anything?

Mr. HORRY. At this point in time we are not for anything else for the simple reason that we believe at some point something radical is going to have to be done, and if something is not done at the present time (or halfway measures that only move in the direction of reform) we are likely to face worse problems next year.

At some point, something radical has to be done. In that sense, we do agree with the administration—but we do not agree with the approach which they have taken, it moves in the wrong direction.

Senator DOLE. How many beds do you represent?

Mr. HORRY. Close to 25,000. I might say one more statement in that regard.

We have received, since our testimony in the House on this exact matter, considerable support from individual hospitals around the country who have written to me personally endorsing the concept—not always in all of its detail. Everyone has quarrels or qualms with certain things. Some endorse it entirely; some endorse with certain exceptions.

But I think that there has been interest and support outside of our membership for the idea that perhaps this is the time to stop the "growth" machinery look at the entire concept.

Senator DOLE. I am not critical. I think it is probably good.

Mr. HORTY. You are questioning its political practicalities.

Senator DOLE. I am trying to count your votes.

Mr. HORTY. Maybe now is the correct time to look at the situation. Maybe we do not have any more time, and maybe it is time to look at total reform.

Senator DOLE. I think you have raised a good idea. Certainly you have made a good statement. You have supported your point of view. I do not know who else supports it. I am just trying to find out.

Mr. HORTY. Most ideas start out with very little support.

Senator DOLE. I learned that.

Thank you.

Senator TALMADGE. Thank you very much, gentlemen, for your testimony.

[The prepared statement of Mr. Horthy follows:]

STATEMENT OF JOHN F. HORTY, PRESIDENT OF THE NATIONAL COUNCIL OF
COMMUNITY HOSPITALS

SUMMARY

1. The National Council of Community Hospitals ("NCCH") welcomes S. 1470 as a constructive effort to face some of the major problems of Medicare-Medicaid reimbursement and as a stimulus to a national debate on how hospitals should be reimbursed under those programs.

2. NCCH, however, opposes enactment of S. 1470 at this time. The most pressing problem is the need to restrain increases in the costs of health care. This should be done immediately. The Administration's bill (S. 1391), however, is inequitable and unconscionably complex. It would add yet another layer of regulatory control. It could well be self-perpetuating and become the control system of the future. This would be chaotic and destructive of the health care delivery system. S. 1470 does not provide immediate cost containment and even in the long run does not attack the fundamental causes for cost increases. NCCH has proposed a program that would effectively attack increases in health care costs immediately and would do so without a complex program or cumbersome bureaucracy. NCCH has proposed that there be a freeze for 24 months on any increases in hospitals' labor intensity and a freeze for 24 months on new capital expenditures related to providing health care.

3. NCCH's proposal would be temporary. It would also force consideration by the American public of long-range structural reforms in the health care delivery system. S. 1470 represents one possible avenue of reform, but NCCH believes it does not address the structural changes that are necessary. NCCH believes that long-range reform will go far beyond adjustments to the reasonable cost reimbursement system, upon which S. 1470 focuses.

4. S. 1470 is inconsistent with the fundamental changes NCCH and others believe are necessary in at least three respects:

(a) S. 1470 is premised on the classification and homogenization of hospitals, while true reform should be built on and encourage diversity.

(b) S. 1470 would add another layer of bureaucracy and Governmental regulation, but fundamental reform should entail the introduction into the health care delivery system of financial incentives, competition, and other measures in place of Governmental regulation (other than quality assurance).

(c) S. 1470 would encourage hospital-based physicians not to enter into arrangements with hospitals but to bill their patients on a fee for service basis. Long range reform will require various arrangements by which physicians are tied more closely to the institution rather than being encouraged to be independent of it. But S. 1470 will remove from hospitals what little leverage they have to negotiate such arrangements with physicians.

STATEMENT

My name is John F. Harty. I am President of the National Council of Community Hospitals, an organization composed of not-for-profit, community hospitals located in 21 States throughout the United States. Our members include some of the best known hospitals in the country. They represent a variety of sizes and types; all are dedicated to providing quality patient care to their communities with the maximum of efficiency. All are deeply dissatisfied with the organization of the current health care delivery system and with the government regulation of it, and all are committed to developing and implementing fundamental reforms of that system. I greatly appreciate, therefore, the opportunity to present the views of NCCH on S. 1470.

NCCH submitted a statement on S. 3205 to this Committee during the last Congress. In that statement, we commended Senator Talmadge and the other sponsors of the Bill for facing some of the most vexatious problems that have arisen in the administration of Medicare and Medicaid programs. We urged that S. 3205 play an important role in provoking a national debate on how hospitals should be reimbursed for the care they provide the beneficiaries of Federal health programs.

We renew those thoughts this year. The sponsors of S. 1470 and their staffs are to be congratulated for tackling some of the hard issues of reimbursement and doing so in a spirit of cooperation with and concern for the health care community—providers and patients alike. However, while we support some of the technical innovations of the bill, we must oppose its enactment at this time. We do not believe this is the proper time to consider S. 1470. We are concerned that concentration of S. 1470 will distract attention from the problems that need immediate action, and may dissipate efforts to develop truly fundamental reforms in the health care delivery system.

The most pressing and immediate need is to restrain increases in the costs of health care. S. 1470 is not an immediately effective cost containment measure. Beyond cost containment, there is wide-spread agreement that structural changes in the health care delivery system must be instituted. S. 1470 provokes debate on the form these reforms should take, but does not envision the fundamental standard changes NCCH believes are necessary and may, I am afraid, only make the task of structural reform more difficult.

The Administration has proposed a cost containment bill and promised a report on fundamental reforms by March 1, 1978. NCCH opposes S. 1391. That bill is inequitable and inordinately complex. It would, in addition, launch a bureaucracy and introduce a mind set that would, we fear, exert considerable pressure to continue the cost containment program beyond the "temporary" duration assumed by the Administration. It might well shelve indefinitely consideration of S. 1470 and other long-range reform measures. Perpetuation of the Administration's cost containment program would be chaotic, and destroy hospitals' financial viability. Even worse, S. 1391 is inconsistent with long-range reforms, and is an obstacle to developing structural changes. It impedes the likelihood that S. 1470 or any other reform measure will be enacted.

NCCH recognizes and endorses the need for immediate cost control measures; at the same time, we believe structural reform is so important it should not be subordinated to a cost containment program that could well become a permanent control system. Nor should cost containment impose another layer of complex, unworkable, and ill-advised regulations on hospitals. NCCH has, therefore, proposed a truly temporary and simple cost containment program that would save approximately the same amount of money as the Administration claims for its program, and would not impede development of true structural reform. At the same time, NCCH's proposal would place hospital boards, management, and medical staff leadership in charge of cost containment and would not replace community management with Governmental bureaucracy. NCCH has suggested that for twenty-four months there be:

1. A freeze on hospitals' labor intensity—the number of FTE's per patient day would be maintained at the current level.
2. A freeze on new capital expenditures by all providers (including physicians).

This freeze would be simple to administer, and it would be effective, resulting in savings in health care expenditure of at least \$1,600,000,000 in the first year. By the terms of the statute we propose and by the practical realities of such a

stringent moratorium, the freeze would be temporary. At the same time, the freeze would force the American public to consider what kind of health care delivery system it wishes to implement when the freeze expires. The freeze would give state and local planning agencies the time necessary to develop the various health plans required by the Planning Act.

It is ironic that hospitals should suggest a freeze, but this is an indication of how absurd the current system is and how great is hospitals' need to be given the tools to maintain and contain costs and how strongly held in their belief that fundamental changes in the health care delivery system must be made—changes which will be considered and instituted only if there is strong impetus to do so.

We have received gratifying support from hospitals and other concerned groups for our proposal. We commend it to your attention. We believe NCCH's proposal warrants your approval, and that it is not inconsistent with the careful consideration of S. 1470 as part of long-range reform.

Our criticisms of S. 1470, set out below, are therefore meant to be constructive and to be considered along with other proposals for reforming the health care delivery system during the 24 months' life of our proposed freeze. Thus, while we cannot endorse S. 1470 in its present form, we believe that your purposes and ours are fundamentally the same. The philosophical difference is that S. 1470 is an effort to reform the existing reimbursement system. We believe it is time to stop, take stock, and evaluate the possibilities of truly radical reform, of developing a new system, rather than reforming the present system. Consideration of S. 3205 last year helped develop NCCH's realization that fundamental reforms are needed. I hope we can persuade you of the need for reforms that go beyond what S. 1470 envisions.

1. S. 1470 is not an effective cost containment measure

S. 1470 is not an immediate cost containment measure. The reimbursement changes proposed by Section 2 of the Bill apparently would not be effective (according to the terms of subsection (d)) until fiscal year 1981—and given the awesome administrative burdens the Bill would entail, we do not believe they could be implemented any more rapidly. The cost of health care is rising too rapidly and is too important a problem to defer cost containment measures for three more years.

More importantly, however, it is difficult to perceive how S. 1470 will be a strong cost-containment measure, whenever it is implemented. The Bill assumes that the cost problem arises from some high-cost and therefore presumptively inefficient hospitals. It is our belief, however, that the real problem is the basic system under which hospitals are forced to operate—which the Bill does, as I discuss below, nothing to rectify.

We do not believe the Bill would effectively save significant amounts of money, for a number of reasons.

First, of course, the Bill applies only to routine operating costs, which account for approximately 50% of a hospital's total costs.

I will discuss later the inappropriateness of attempting to classify hospitals and the irrelevance of pegging reimbursement to the average cost. But even setting those difficulties aside, the mechanism proposed by Section 2 would do little to prevent even routine operating costs from rising. The Bill does not address the fact that the average is a floating average and that it will inevitably float higher because system pressure, not inefficiencies of individual hospitals, cause higher costs. The Bill does not discourage hospitals—regardless of utilization and "profitability" factors—from purchasing expensive new equipment, which can increase routine operating costs. Experience to date has shown that planning cannot be counted upon to stop this expensive proliferation. Nor does the Bill prevent doctors from ordering additional tests or providing new services which may require longer stays and increase routine operating costs.

Third, the Bill might encourage some hospitals to raise their costs. Hospitals at the average cost will be encouraged to raise their costs to take advantage of the 120% range offered by the Bill. Those below the average will be encouraged to rise to the average (and from there to 120% of the average). The Bill offers the so-called incentive of permitting hospitals whose routine operating costs are below the average to retain a percentage of that differential. But we can foresee hospitals who would prefer to retain 100% of the differential, rather than a percentage of it, and will offer a sufficient number of improved services so that operating costs rise to the average. By doing so, the hospitals would have the

benefit of the entire amount of the differential between their prior cost and the average cost of the class. They might find these improved services preferable to keeping only part of the differential, which would pay for only a smaller amount of new service.

Fourth, because the proposed system is tied to average routine operating costs per patient day, the Bill introduces incentives to lengthen stays and to increase admissions—factors which can only increase the total health care cost, although lowering it on a unit basis.

Finally, the Bill entails tremendously complex calculations for each hospital and for the Government. The Bill would require determination of the classifications, determination of index rates for the "area" in which each hospital is located, and determination of the increase in the cost of each hospital's mix of goods and services. These calculations cannot be taken out of a reference book. The Bill would require resolution of a number of additional questions: *e.g.*, did the hospital "manipulate" its patient mix or flow; does it provide less than the "normal" range of patient services; do its patients require "a substantially greater intensity of care"; what portion of its routine operating costs are "attributable to the greater intensity"; etc. These are no simple questions. They will have to be resolved by the thousands. Doing so will be expensive.

In addition, the Bill introduces uncontrollable uncertainties, which can only further complicate the problems hospital management must deal with. How, for instance, can a hospital whose fiscal year begins in January budget when it will not be informed of HEW's calculation of its adjusted per diem payment rate until April 1? These complexities can only increase hospital costs and the costs of Medicare-Medicaid administration.

2. S. 1470 does not embody structural reforms

In introducing S. 1470, the Chairman of this Subcommittee referred to the Bill as a long-term solution to the cost containment problem. NCCH is pleased that the Chairman recognizes the need for long-range reform. But we must respectfully note that S. 1470 does not present fundamental long-range reform. S. 1470 makes highly complex adjustments in the present reasonable cost reimbursement system, but it does not change the basic system.

As my statement last year on S. 3205 discussed, there is widespread dissatisfaction, on the part of both the Government and the hospitals, with the reasonable cost reimbursement system. The reasonable cost system contains a number of inherent difficulties:

"Reasonable cost" represents the ultimate in conflict of interest. It permits HEW to determine what is reasonable cost for the services it is purchasing. Not surprisingly, we have observed in the past few years numerous occasions on which HEW has restricted what is "reasonable," not because a service was unreasonable or unnecessary or because the cost of the service actually was unreasonable as a financial matter, but only because the Government sought ways to reduce Federal expenditures for health care. The Government has transformed a system that was intended and designed to prevent hospitals from overcharging the Government into a mechanism for underreimbursing them.

Reasonable cost entails a vast army of Federally employed and Federally activated accountants whose sole mandate is to save the Federal dollar without consideration of the effect on the provision or quality of care. Reasonable cost requires expensive and time-consuming audit of the thousands of participating hospitals.

Reasonable cost makes no allowance for the fact that even not-for-profit hospitals need a "profit" to provide them with working capital and discretionary funds.

Reasonable cost subjects hospitals to a process of review and second-guessing years after the services have been performed, and after the reimbursement has been approved and paid by the Government itself.

As a result of these and other problems with the reasonable cost system of reimbursement, NCCH determined to develop a more effective and fairer method of reimbursement. It soon recognized that the reimbursement system cannot be changed without changing the structure of the delivery system.

S. 1470 does not approach those needed changes. Classifying hospitals, pegging reimbursement to certain arbitrability selected levels, and indexing costs represent fine tunings of the reasonable cost system. They do not address the problems inherent in any system of reimbursement based on reasonable costs, and they do not point the way to a new delivery system. Indeed, a larger number of functionaries, both in hospitals and the Government, would be required to administer the pro-

posed system. As discussed above, the Bill introduces a host of complex calculations and determinations. The inevitable result will be additional phalanxes of accounts, economists, statisticians, systems analysts, lawyers, and associated personnel.

Nor does S. 1470 prevent the Government from continuing to cut back on what it is willing to recognize as a reasonable cost. Indeed, S. 1470 would make those unwarranted determinations applicable to all hospitals (by reducing the average). And S. 1470 would give the Government yet another tool to assert its self-interest: reimbursement pegged at the average of a class and limited to 120% of the average could always be lowered by changing those arbitrary standards.

We also note that S. 1470 would exacerbate the reasonable cost system in another way. At the present time, hospitals that are not reimbursed by Medicare-Medicaid for the full and fair cost of caring for these Federal beneficiaries are forced to transfer these costs to private patients. S. 1470 (Section 2(f)(1)) would prohibit such a transfer. This can only result in impairing the financial stability of hospitals or forcing them to eliminate the services they are now providing Federal beneficiaries for which they are not fully reimbursed. We would think a more just provision would be one that required the Federal Government to pay the full cost of hospital services its beneficiaries receive.

S. 1470 does not do anything for a not-for-profit hospital's need for a "profit." The incentive payment in the Bill is not a profit. As I mentioned above, hospitals could well decide they would be in a better position by increasing their expenditures to the permitted average than by keeping a small percentage of what they can save. Also, the money made available by this provision would go to the hospital offering the least services (and whose routine operating costs, therefore, are below the average)—while the more active, more innovative hospital is deprived of discretionary funds. All hospitals need an operating margin.

3. S. 1470 will in fact impede necessary structural reforms.

NCCH believes that long-range structural reforms must contain at least the following elements: financial incentives for providers to restrain health care costs; management discretion, including the opportunity to benefit from success and the obligation to bear the burdens of failure; mechanisms that require both health care providers and patients to consider the cost as well as the benefit of any particular health service; increased control by health care institutions of the source of their "business"; increased competition among health care institutions to serve patients with better quality of care at lower cost; recognition of the benefits of diversity among health care providers; and greatly reduced Government control over the management of a health care institution except in the area of quality assurance.

I believe these principles will find widespread acceptance by the health care field, the Government, the medical profession, and patients. We believe that there is sufficient consensus as to the outlines of structural reform that we should be certain that no measures are implemented which would be inconsistent with these reforms or make their implementation more difficult. It is our confidence that reform is possible that made us propose the 24-month freeze.

S. 1470, NCCH believes, would hold back long-range reforms. There are three major premises of the Bill that we believe are inconsistent with true structural reform.

a. Hospitals should not and cannot be classified but S. 1470 would promote their arbitrary classification

A basic premise of S. 1470, I fear, is that diversity among hospitals should be discouraged, and if possible, eliminated. The Bill would force hospitals into grossly determined classifications, and set their reimbursement on the basis of the costs of other hospitals who happen to be in the same classification. This approach totally ignores the ways in which hospitals of the same "type" and "size" (the two criteria employed by Section 2) may be different.

We do not believe that it is possible to categorize hospitals. They are far too diverse to permit classification, except by a complex of matrixes that is so sophisticated that it is yet to be developed. HEW's efforts in this direction, pursuant to Section 1861(v)(1)(A) of the Act, have been grossly simplistic and have unfairly lumped disparate hospitals together. We have no reason to believe that classifications made under Section 2 would be any different.

We doubt that classification of hospitals would work even with the most sophisticated system and we believe it is a false way of handling reimbursement.

No two people are alike. Hospitals are nothing but aggregates of the interaction of many individuals (including those who shaped the institution in prior years) and to classify hospitals is even more impossible than classifying individuals.

Even if, after spending millions of dollars, some sufficiently sophisticated classification system were developed, moreover, it would be outmoded the next day, for institutions are and should be perpetually changing. They cannot—and should not—be fast-frozen. Classification, in short, is impossible for living things.

The safety valve in Section 2 by which the payment rate would be readjusted for any hospital which the Secretary determined provided "substantially greater intensity of care" is not workable. Experience has shown that the Secretary is reluctant to make such determinations (which result in additional Federal payments) and that even if he does, they are made years after the event. In any event, how does the Secretary determine what is substantially greater intensity of care? There are, moreover, a vast number of variables among hospitals in addition to intensity that affect cost. Every hospital is different from every other. The unusual is commonplace.

The effort by S. 1470 to squeeze every hospital into categories is, if I may mention two legends, akin to the endeavors of King Canute and Procrustes combined. Diversity should be welcomed and promoted. It is a threat only to those who wish to exert centralized Governmental control. S. 1470, therefore, is inconsistent with the directions in which NCCH and others believe structural reform and the best and most efficient health care system lie.

b. Although bureaucracy in this field should be reduced, S. 1470 would add yet another layer of bureaucratic control

NCCH does not believe the structural reform of the health care delivery system is advanced by a system under which the Federal Government would set reimbursement for all hospitals on the basis of arbitrary percentages of artificially created categories of hospitals. There is no reason to believe that a hospital which exceeds the average cost of the hospitals in the category in which the Secretary has placed it is by virtue of that statistic alone inefficient. That hospital may provide additional (or different) services. A vibrant, innovative health care system is not promoted where the Government sets reimbursement on a totally arbitrary basis and reserves for itself the right to set some other arbitrary rate when it so chooses.

In addition, S. 1470 would, as discussed above, increase the complexity of an already overwhelmingly complex system and require a new army of accountants, economists, statisticians, bureaucrats, lawyers, and the like. This growth of the bureaucracy is harmful by itself. It calcifies the entire system. The more complex the reimbursement system, the more innovation and risk-taking are discouraged. Management must focus on working within a complex set of rules; Government must strive to assert the primacy of its rules and protect their efficacy. The more entrenched such a system is, the more difficult it becomes to reverse the trend and develop a health care system that can function without the daily and minute control of the Governmental dead hand.

c. Managerial innovation and excellence is essential to the future strength of this field, but S. 1470 impedes hospitals' efforts to exert managerial control

An essential component of any structural reform must be enhancement of a hospital's ability to manage its own "business." Hospitals are the only institution I know of that have virtually no control over their "sales force" (primarily physicians), little control over their "production department" (physicians, and even a hospital's own employees), and no direct connection with their "customers" (patients). Until hospitals can determine what patients they serve, what services are provided, and when, it will be possible for them to introduce financial considerations into the provision of health care or to control their own expenditures. To increase the efficiency of the system, to widen access, and to introduce financial incentives, hospitals will have to develop different and more meaningful ties with their patients and be more directly responsible for the provision of health care.

In his speech before the Hospital Association of Pennsylvania last October, Senator Talmadge recognized that hospitals do not have the legal authority or the power to make the decisions that largely determine the cost of care because

the medical staff decides admissions and length of stay, what tests are performed, and so on. Senator Talmadge continued by saying that we "cannot continue to accept that reality as an excuse forever."

We agree with Senator Talmadge as to hospitals' inability to make those decisions, but we believe that the reality cannot be ignored or brushed aside. Ways must be found to change this reality so that hospitals can control costs. This is a prime element of the reforms needed in the health care delivery system. But S. 1470 does nothing to increase hospitals' ability to control their own costs; the Bill actually impedes efforts by hospitals to work out more effective relationships with their physicians.

I refer, of course, to Section 12, which effectively precludes any arrangement (other than a salaried employee relationship) between a hospital and any physician for the physician to perform medical services at the hospital. We understand and share the current disquietude over the amounts of money some physicians receive. But even if it is wise as a matter of public policy for the Government to be in the position of imposing compensation limitations on one small segment of society, Section 12 is not an effective mechanism for doing so. Putting hospital-associated physicians on a fee-for-service basis is no guarantee that the total amount of their compensation will be any less than it was under the hospital arrangement. It is likely to be more, and it certainly will be more difficult for anyone to know what the physician's total compensation is. Except to the extent ignorance of the outcome can be masked as a solution, then, Section 12 is unlikely to be effective.

At the same time, and of more importance for long-range reform, Section 12 will destroy hospitals' efforts to tie physicians more closely to the institution. By its terms, Section 12(c) would limit the physician's compensation under any arrangement to the amount he would receive if he had been on a salary. I imagine it may be rather difficult to calculate what a physician would have received if he had been on salary.

But the provision would have far more harmful results than merely enhancing the complexity of the system. As applied by the bureaucracy, the provision certainly will limit physicians' compensation to less than what they will receive under fee-for-service. This, plus the "ethical" arguments that will be raised in favor of fee-for-service will effectively prevent any "arrangement" between community hospitals and their physicians. Hospital associated physicians would be given an overwhelming incentive to refuse any arrangement with the hospital and go to fee-for-service.

As a consequence, most of the ties that these arrangements generate between a hospital and their physicians would be broken. It is an elemental fact that a person who is paid by the hospital feels more loyalty to the institution and is more willing to cooperate with hospital management in cost and quality control than is one who receives no funds from the hospital, but only uses it as a workplace. Furthermore, arrangements between hospitals and physicians give the hospitals leverage to obtain better service. To ensure around-the-clock coverage by a radiology group, for instance, a hospital may offer the group a contract. The existence of a contract gives the hospital a vehicle for enforcing quality, for ensuring that the contracting physicians mesh their operations with other hospital services, for obtaining administrative and educational services from them, et cetera. If hospitals are prevented from entering into such arrangements with physicians, they will be deprived of their main bargaining counter. How will the community hospital provide radiology around the clock, 24 hours a day, if it has nothing to give the radiologist in exchange for his agreement to provide such services? A physician on fee for service will tend to work at the hours when there is the most amount of potential "business." Section 12, therefore, will impede hospitals' efforts to provide quality care in the short term, and it will set back efforts to tighten the relationship between hospitals and physicians and thus discourage long-range reform efforts.

I recognize that Section 12(c) was spurred by a suspicion of percentage contracts. But the effect is overkill. The Bill is not limited to those arrangements. And even if it were, NCCH would oppose the provision. Percentage contracts are abused by some physicians. But that does not justify prohibiting the arrangement. The fault is not in percentage contracts themselves. Such contracts are in many instances an effective and fair way for the hospital to obtain specialty services. A hospital should be left free to use whatever arrangement it deems best. To the extent there are "abuses" of percentage contracts, they are a result

of poor negotiating or of the hospital's lack of bargaining power. In such a market, the physician will be able to collect comparably high compensation no matter what arrangement (including fee-for-service) is used. The problem can best be faced by changing the market pressures, and the hospital's leverage, not by futilely trying to reverse the consequences of those pressures and reducing the hospital's leverage.

An increasing number of physicians are being produced. It is possible that within four or five years, the market will swing into a more realistic balance. Hospitals will then be able to negotiate more advantageous arrangements with physicians who wish to use their facilities. But Section 12 would prevent them from doing so (except to the extent they are able to obtain salaried physicians). Section 12 leaves no room for the hospitals to develop innovative arrangements with doctors in the broad area between fee-for-service on one extreme and physician employees on the other. Structural reform of the system requires the development of such arrangements, but Section 12 would defer that effort.

CONCLUSION

For these reasons, NCCH must respectfully oppose S. 1470 at this time. We urge consideration of our proposal for a short-term freeze, designed to contain cost increases immediately and to force a wide-ranging consideration of what kind of health care delivery system the American people desire. The ideas developed in S. 1470 could play an important part in formulating structural reform, although, as my testimony has indicated, NCCH believes the health care delivery system needs changes that go beyond those proposed by S. 1470.

I appreciate the opportunity to appear before you today.

Senator TALMADGE. The next witness is Dr. Charles E. Phillips, president, American Protestant Hospital Association. I understand he is not present. His statement will be inserted in the record.

[The prepared statement of Dr. Phillips follows:]

STATEMENT OF CHARLES D. PHILLIPS (ED.D.), PRESIDENT, AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Mr. Chairman, I am Charles D. Phillips, President of the American Protestant Hospital Association, representing some 300 hospitals, homes for the aging and other health care agencies throughout the country, as well as some 2,000 personal members who are engaged in the delivery of health care services. The Association membership is dedicated to providing quality health care to patients within a Christian reference and to ensuring the strength and viability of our voluntary, pluralistic health care delivery system. With me is Michael S. Casedy, the Director of our Government Affairs Department.

We greatly appreciate the opportunity to present the position of APHA on S. 1470. Mr. Chairman, let me say at the outset that the members of APHA appreciate your concern about the rising costs of the Medicare and Medicaid programs to the taxpayers of this nation. We are grateful for your commitment to the development of reforms which will prevent the cutting and slashing of payments to hospitals and physicians indiscriminately and inequitably and the imposing of arbitrary controls and indiscriminate limits on payments to hospitals such as the Administration's proposed ceiling on hospital cost increases.

We are concerned, however, that the reforms which are proposed as solutions to the problem of escalating costs of hospital services under Medicare and Medicaid be based on an awareness of the factors which are responsible for such increases, and that the reforms address those factors rather than taking a simplistic approach of limiting reimbursement. We believe that this bill demonstrates your awareness of the enormity of the problems faced both by the federal government and the health care institutions of this nation and that it is a step in the direction of addressing needed reform.

Mr. Chairman, we will comment on only certain sections of this bill which we feel are of more crucial significance to our members.

SEC. 2. Criteria for determining reasonable cost of hospital services

APHA is confused over the intent of the provision whereby the Secretary shall establish an "accounting and uniform functional reporting system" to

determine hospital operating and capital costs. If this means a uniform accounting system will be mandated for all hospitals, then we must oppose it as an infringement upon management prerogative. However, if the intent is for the Secretary to devise a uniform cost reporting system in order to facilitate cost comparisons between like hospitals, then we support the proposal.

The APHA is also concerned with the proposal for the classification of institutions for the purposes of reimbursement on a comparative basis. We can understand the attractiveness of such a methodology to the federal government. However, we feel that great difficulty will be experienced in the technical aspects of devising such a methodology for classifying institutions for purposes of reimbursement. The fact that S. 1470 deletes from the comparison procedure for routine per diem hospital costs some of the elements over which an institution has little or no control is a vast improvement over section 223 of Public Law 92-603.

We suggest that the classification system be devised with full consultation from the field of health care and government agencies. We therefore recommend that this committee bring together a group of technical experts who have been involved in Medicare-Medicaid reimbursement matters over the years. Representatives should include persons from associations of providers, Social Security Administration, health care institutions, congressional staff, Blue Cross Association, and etc. These experts would discuss in depth the basis for the classification system and the appropriateness and the validity of the components now included in this bill. We believe that the formation of such a panel of experts would be in keeping with the spirit of openmindedness expressed by the chairman when you introduced the bill and that it would prove to be of substantial assistance in forming a workable and equitable method of classification.

APHA is on record as supporting a reimbursement system which includes prospective reimbursement administered on a state level under federal guidelines. We are pleased to see the inclusion of a state administered rate review option for the determination of institutional reimbursement that could be based upon prospective payment methodology if a state so chooses. APHA feels that state level rate review on a prospective basis is more likely to assure that the variables among institutions, which are often very local, are taken into account and that the full financial requirements of the institutions are provided.

SEC. 3. Payments to promote closing and conversion of underutilized facilities

We support the demonstration project proposed in Section 3 by which federal financial support would be provided institutions which apply for such support on the basis that their operations would be made more efficient or cost-effective by the closing or conversion of underutilized beds and that they would also become eligible for positive incentives under the provisions of section 2.

SEC. 12. Hospital—Associated physicians

We recognize that the problem which this section attempts to address is not a new one for hospitals or the government. We express grave concern, however, over the proposal that the federal government involve itself with such specificity in determining the types of contractual arrangements between hospitals and physicians. We recognize that cases of unreasonable compensation can be documented, but believe that to enact legislation prohibiting a specific type of contract removes decision making from its proper authority—management and the governing boards—and places it in Washington. Financial incentives for efficient hospital administration contained in other sections of this bill will effect the desired result by encouraging the administrators to find areas in which savings might be made, including this area of contractual arrangements with physicians if an individual administrator so chooses.

We are concerned further that as section 12 is written, it will not accomplish the intended result of reducing hospital costs. There are those who have studied this proposal who are convinced that the aggregate costs resulting from categorizing the various services of these physicians and the mandating of a fee-for-service basis of reimbursement for personal patient services will be greater than those now being experienced.

SEC. 30. Establishment of Health Care Financing Administration

We are pleased to note that the President and the Secretary of HEW have adopted administratively your proposal for a Health Care Financing Administration, incorporating the old Bureau of Health Insurance, Bureau of Quality Assurance, Medical Services Administration and the Office of Long-Term Care.

However, we share your concern that the new agency, rather than collapsing overlapping positions and clarifying lines of authority, may do the opposite and establish a new bureaucratic superstructure as a haven for displaced bureaucrats. We support, therefore, your keeping this provision in the bill. In addition, we continue to recommend, as we did in testimony before you last summer, the creation of a cabinet-level Department of Health as a mechanism for the most effective coordination of the setting of national health policies and administration of federal health programs.

SEC. 31. State medicaid administration

This section reflects the awareness of the Chairman of the problems besetting hospitals because of the performance of states in administering Medicaid. We support the proposal to establish specific performance criteria for state administration of Medicaid which will result in more prompt payment of claims and vastly improved administration of the program.

SEC. 40. Procedures for determining reasonable cost and reasonable charges

APHA vigorously opposes this section. The Medicare law already contains adequate provisions to determine reasonable costs. Further, the proposal is a gross infringement on the management prerogative of individual institutions.

SEC. 46. Rate of return on net equity for for-profit hospitals

APHA supports the principle implemented in this section—that an adequate return on investment is a reasonable expectation in business. By the same principle, we urge the Committee to amend this section to provide for an adequate operating margin on reimbursement by Medicare and Medicaid to not-for-profit institutions, since no institution can continue to operate only on the basis of costs. Determined for the various classes of nonprofit hospitals, the operating margins would reflect factors unique to these facilities such as the costs of charity care, educational programs, and generally more acute level of care provided.

SUMMARY OF RECOMMENDATIONS

Mr. Chairman, in conclusion we would like to summarize some of the recommendations that we have made here today.

Under Section 2:

1. We support a uniform functional reporting system to facilitate cost comparisons between like hospitals. However, we are opposed to a mandated uniform accounting system for all hospitals as it would be an infringement on a right of management.

2. We recommend that the Committee, in devising the classification system to determine reimbursement, consult in depth with a panel of experts drawn from association providers, hospital executives, Social Security Administration, Blue Cross and other third party payers, congressional staff and others.

Under Section 12:

3. We recommend leaving the choice of hospital-physician contractual arrangements with management. The financial incentives for efficient hospital management contained elsewhere in this bill are adequate to address the problem of unusually high payment to hospital-associated physicians.

Under Section 30:

4. We support keeping the legislative provision for the creation of the Health Care Financing Administration. We further recommend the creation of a cabinet-level Department of Health as a mechanism for the coordination of the setting of national health policies and the administration of all federal health programs.

Under Section 40:

5. We recommend the deletion of Section 40 in its entirety.

Under Section 46:

6. We recommend the Committee amend this section to provide an adequate operating margin, since no institution can continue to operate only on the basis of costs.

Mr. Chairman, we thank you and members of this Committee for considering these views and for giving us this opportunity to appear before you. If we can answer any questions you might have now or later on any technical aspects of our recommendations, we will be happy to do so.

Senator TALMADGE. The next witness is Bruce D. Thevenot, administrator, Government Services Division, American Health Care Association.

We are delighted to have you back before our committee as a witness. You may insert your full statement into the record and summarize it.

STATEMENT OF BRUCE D. THEVENOT, ADMINISTRATOR, GOVERNMENT SERVICES DIVISION, AMERICAN HEALTH CARE ASSOCIATION

Mr. THEVENOT. My statement is brief this morning. I will confine my comments principally to those which relate directly or indirectly to long-term care providers.

As you know, the American Health Care Association is the Nation's largest organization representing nursing homes. Presently, Mr. Chairman, we have some 7,500 members in the association which represent about half of the industry nationwide. That includes about 600,000 beds at the present time.

As I said, in view of our lengthy testimony on S. 3205 last year, I shall make my comments brief today.

I should first like, however, to commend the chairman of this subcommittee for his willingness to incorporate a number of constructive suggestions made during last year's hearings. As a result, a good bill has been made better. It seems to me that S. 1470 is on target in its overall approach and concept, and is well thought out in its particulars. This legislation should be enacted as soon as possible.

While the reimbursement reforms proposed in section 2 would not initially apply to long-term care facilities, AHCA would like to indicate its support of the important principles upon which these reforms are based. Section 2 is a large step in the direction of rational pricing of institutional health services. This step, and succeeding steps, must be taken now if long-range price stability is to become a reality in the health care sector. By contrast, the President's proposed cost containment plan, though well meaning, is simplistic, inequitable and potentially disruptive.

I would like to point out to the subcommittee that reimbursement systems similar in concept to the methodology proposed in section 2 have been and are being put into effect for nursing homes by a number of State Medicaid programs under the requirement of section 249 of the 1972 amendments that skilled nursing and intermediate care facilities be paid on a reasonable cost-related basis. Currently by our count, some 29 States have in place some form of prospective rate setting for nursing homes which includes incentives designed to reward efficient performance.

In this respect, reform of payment methods for nursing homes are somewhat farther advanced than for hospitals, owing to the earlier legislative mandate and the relatively smaller degree of complexity involved.

Therefore, while we strongly support the approach suggested in section 2, we believe that any future consideration to apply this particular system to long-term care facilities should take into account the status of the implementation of section 249.

I would like to comment on two additional sections of the bill that are quite similar in approach. Section 3 would authorize payments to

promote the closing or conversion of underutilized facilities; section 20 would make changes in current law designed to facilitate the conversion of excess hospital capacity to long-term care services. I am aware, Mr. Chairman, that there has been considerable discussion recently of the feasibility of simultaneously solving the problems of too many hospital beds and too few nursing home beds by placing the excess hospital beds into service as long-term care beds.

AHCA believes this assumption has practically no validity in the case of truly long-term patients, and only limited potential in the case of posthospital convalescent patients.

We are therefore pleased to see that S. 1470 takes a cautious and measured approach to the conversion of excess hospital capacity. In general, it is our expectation that closure or "mothballing" will be the most practical solution in the majority of instances, and we support the provisions in section 3 for financial assistance to hospitals to discontinue underutilized operations.

Section 20 permits, under limited circumstances, certain rural hospitals to provide long-term-care services. AHCA supports the requirement in this section for a certificate of need, and the limitation of per diem payments for routine services to the prevailing rates for free-standing facilities in the State.

We would like to suggest again a modification, this time to section 4, in that provision relating to Federal participation in disapproved hospital capital expenditures. A number of provider organizations, including ours, raised the point in testimony last year suggesting that section 1122 be further amended to make it clear that prior approval is not required of simple changes of ownership—that is, where there are no additional beds or equipment and no change of service.

It was our understanding that this suggestion conforms with the original intent of the Finance Committee.

Senator TALMADGE. I think that is a good suggestion, and we will probably agree to that.

Mr. THEVENOT. Thank you, Mr. Chairman.

Section 21 relates directly to reimbursement of skilled and intermediate care facilities. It would make the statute clear with regard to the flexibility given to the States to include as a part of its payments to nursing homes reasonable amounts for profit and it specifies the methods by which these amounts can be earned.

Recent HEW policy limits these allowances to an amount figured on the invested equity of the proprietary owner and permits no earnings allowance whatever for nonproprietary facilities. This policy is unduly restrictive, and effectively prevents the establishment of incentive based payment systems by removing the incentive feature. Therefore, section 21 is crucial to assure that States are able to establish cost-effective payment methods while attracting necessary capital investment in nursing homes.

Section 22 would transfer the final authority to certify and approve for medicaid purposes skilled nursing and ICF's to the Secretary of HEW. I believe, Mr. Chairman, that this particular provision has been greatly improved over the comparable provision in S. 3205 by the addition of provisions for hearings and appeals with AHCA strongly supports.

Frankly, though, Mr. Chairman, we remain skeptical that this transfer of authority will be the secret to uniform application of health and safety standards. The unnecessary complexity, paperwork, and duplication of inspections by Federal, State, and local health, licensure and other related and unrelated authorities seem doomed to continue as long as these agencies refuse to recognize standards and surveys on a reciprocal basis.

We continue to support the provision in section 23 which would liberalize the policy toward permitting patients of nursing homes to make visits away from the facility. We believe this provision recognizes the therapeutic value of these visits away from the institution, therefore, we think it is certainly in the best interests of the patients, and we support this change without reservation.

I would like to make a final comment concerning the President's cost containment proposal at this point. Mr. Chairman, as you are aware, the President's proposal does not presently apply to long-term care facilities. I am certainly not here to allege any discrimination in that respect. We believe that there are excellent reasons to support the exclusion of nursing homes from the President's proposal.

Among the best reasons are No. 1, that the nursing homes per diem costs have risen relatively modestly. Indeed, it seems to us that the 9-percent cap would be almost completely superfluous.

Secondly, there is presently no surplus of long-term care beds nationwide, hence an overall capital expenditures limit without regard to need would be very unwise indeed at this time.

Third, it should be understood clearly that the very real problem that exists, insofar as medicaid expenditures for long-term care are concerned, is largely the result of increased utilization and not due to increases in the per diem costs or rates being paid to nursing homes.

For these reasons, AHCA would be strongly opposed to any congressional decision to broaden the President's plan to include long-term care facilities. On the contrary, we would urge greater incentives for the use of long-term care facilities, HMO's, home health care and other alternatives to hospitalization where appropriate.

I would conclude my remarks, Mr. Chairman, by thanking you again for enlisting the cooperation of the many groups that will be affected by this legislation. The results of this process are evident. It seems to us that S. 1470 is realistic, it is constructive, and it ought to be given expeditious consideration by the Senate and by the House.

Thank you.

Senator TALMADGE. Thank you, very much, Mr. Thevenot for your constructive suggestions. We also appreciate the fact that your American Health Care Association has worked closely with our staff in drafting our bill.

Do you have any questions, Senator Dole?

Senator DOLE. Is it true that we spend more for long-term care in nursing homes and medicaid than we do in hospitals?

Mr. THEVENOT. According to the most recent statistics I have seen, they are both in the neighborhood of 39 to 40 percent of the total medicaid expenditures. That is an important point, Senator Dole.

Expenditures for nursing home care tend to be located primarily in the medicaid program; somewhat more than 50 percent, I believe, of

all of the revenues derived by nursing homes are coming out of the medicaid program, so that the impact of expenditures has a disproportionate effect on that particular program.

I might point out to you that the medicare program, by contrast, is spending less money in real dollars than it was in 1969. Medicare accounts for a very marginal share of any of the expenses related to nursing homes.

Senator DOLE. The only point I make, all the focus has been, at least as I look back on it, has been on hospital costs as it relates to medicaid—maybe not on nursing homes or other long-term care facilities. The primary focus has been on hospital costs. Most of the comments and things I have read have dealt with the hospital costs rather than nursing homes, or long-term care facilities.

I can understand that there would be an impact on these as well.

Mr. THEVENOT. You are quite correct, sir. It is, however, a question of unit prices versus program expenditures.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much for your testimony.

[The prepared statement of Mr. Thevenot follows:]

STATEMENT OF BRUCE D. THEVENOT ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and members of the subcommittee, I appreciate this opportunity to share with the subcommittee the views of the Nation's largest organization of long-term care facilities concerning S. 1470. In view of our lengthy testimony on S. 3205 last July, I shall confine my comments to those provisions of S. 1470 which are of direct or indirect interest to long-term care providers.

I should like first, however, to commend the chairman of this subcommittee for his willingness to incorporate a number of constructive suggestions made during last year's hearings. As a result, a good bill has been made better. It seems to me that S. 1470 is on target in its overall approach and concept, and is well thought out in its particulars. This legislation should be enacted as soon as possible.

SEC. 2. Criteria for determining reasonable cost of hospital services

While the reimbursement reforms proposed in Section 2 would not initially apply to long-term care facilities, AHCA would like to indicate its support of the important principles upon which these reforms are based. Section 2 is a large step in the direction of rational pricing of institutional health services. This step, and succeeding steps, must be taken now if long range price stability is to become a reality in the health care sector. By contrast, the President's proposed cost-containment plan, though well-meaning, is simplistic, inequitable and potentially disruptive.

I would like to point out to the Subcommittee that reimbursement systems similar in concept to the methodology proposed in Section 2 have been and are being put into effect for nursing homes by a number of State Medicaid programs under the requirement of Section 249 of the 1972 amendments that skilled nursing and intermediate care facilities be paid on a reasonable cost-related basis. Currently, by our count, some 29 states have in place some form of prospective rate setting which includes incentives designed to reward efficient performance.

In this respect, reform of payment methods for nursing homes are somewhat farther advanced than for hospitals, owing to the earlier legislative mandate and the relatively smaller degree of complexity involved.

Therefore, while we strongly support the approach suggested in Section 2, we believe that any future consideration to apply this particular system to long-term care facilities should take into account the status of the implementation of Section 249.

SEC. 3. Payments to promote closing and conversion of underutilized facilities

SEC. 20. Hospital providers of long-term care services

There has been considerable discussion recently of the feasibility of simultaneously solving the problems of too many hospital beds and too few nursing home beds by placing the excess hospital beds into service as long-term care beds.

AHCA believes this assumption has practically no validity in the case of truly long-term patients, and only limited potential in the case of post-hospital convalescent patients.

We are therefore pleased to see that S. 1470 takes a cautious and measured approach to the conversion of excess hospital capacity. In general, it is our expectation that closure or "mothballing" will be the most practical solution in the majority of instances, and we support the provisions in Section 3 for financial assistance to hospitals to discontinue underutilized operations.

Section 20 permits, under limited circumstances, certain rural hospitals to provide long-term care services. AHCA supports the requirement in this section for a certificate of need, and the limitation of per diem payments for routine services to the prevailing rates for free standing facilities in the state.

SEC. 4. Federal participation in hospital capital expenditures

AHCA urges that these suggested modifications in Section 1122 of the Act be further amended to make clear that prior approval is not required of simple changes of ownership involving no addition of beds or equipment and no change of service. A number of provider organizations, including AHCA, raised this point in testimony on S. 3205 and understood that our suggestion conformed with the original intent of the Finance Committee when it enacted Section 1122. I therefore suggest again that S. 1470 be so amended.

SEC. 21. Reimbursement rates under medicaid for skilled nursing facilities and intermediate care facilities

AHCA strongly supports this amendment to present law. Section 21 would make it clear that states may include reasonable amounts for profit as part of its payments on a reasonable cost-related basis. It further specified the manner in which these amounts can be earned. Recent HEW policy limits these payments to an amount figured on the invested equity of the proprietary owner and permits no earnings allowance whatever for non-proprietary facilities. This policy is unduly restrictive, and effectively prevents the establishment of incentive based payment systems by removing the incentive feature. Therefore Section 21 is crucial to assure that states are able to establish cost-effective payment methods while attracting necessary capital investment in nursing homes.

SEC. 22. Medicaid Certification and Approval of Skilled Nursing Facilities and Intermediate Care Facilities

This section, which transfers to the Secretary of HEW final authority for the certification of Medicaid SNF's and ICF's, has been greatly improved over a comparable provision of S. 3205 by the addition of provisions for hearings and appeals which AHCA strongly supports.

In all candor, however, we remain skeptical that this transfer of authority is the secret to uniform application of health and safety standards. The unnecessary complexity, paperwork, and duplication of inspections by Federal, state, and local health, licensure, and other related and unrelated authorities seem doomed to continue as long as these agencies refuse to recognize standards and surveys on a reciprocal basis.

SEC. 23. Visits away from Institutions by Patients of Skilled Nursing or Intermediate Care Facilities

AHCA continues its endorsement of this provision which recognizes the therapeutic value of visits away from an institution and provides a more flexible policy on such visits.

Additional Provisions

AHCA is supportive of the administrative and other miscellaneous improvements contained in S. 1470. The only exception is Section 33, which would abolish the Health Insurance Benefits Advisory Council. AHCA supports the continuation and revitalization of HIBAC.

S. 1391, H.R. 6575

Mr. Chairman, the President's cost containment proposal would not apply to long-term care facilities. We believe there are excellent reasons to support this

exclusion. Among the best reasons are: (1) nursing home per diem costs have risen relatively modestly; indeed a 9% cap would be almost completely superfluous; (2) there is no surplus of long-term care beds nationwide, hence an overall capital expenditure limit without regard to need would be very unwise; and (3) utilization, not inflation, has been the primary force behind the rapidly increasing Medicaid expenditures for nursing home care. (*Medicare* expenditures for extended care are currently less than they were in 1969 in real dollars).

For these reasons, AHCA would be strongly opposed to any Congressional decision to broaden the President's plan to include long-term care facilities. On the contrary, we would urge greater incentives for the use of long-term care facilities, HMO's, home health care and other alternatives to hospitalization where appropriate.

CONCLUSION

In summary, AHCA urges this subcommittee to proceed expeditiously on the mark-up and reporting of S. 1470. I would also like to thank the Chairman for eliciting the cooperation of the many groups affected by this legislation. The results of this process are evident. S. 1470 is realistic and constructive legislation which recognizes that our present programs must be put in order before any attempt to expand benefits can be seriously contemplated.

Senator TALMADGE. The next, and final, witness today is Mr. Harry Asmus, president, National Council of Health Care Services, accompanied by Jack MacDonald, executive vice president.

Mr. Asmus, you may insert your statement in full in the record and summarize it in 10 minutes, if you will.

STATEMENT OF HARRY ASMUS, PRESIDENT, NATIONAL COUNCIL OF HEALTH CARE SERVICES, ACCOMPANIED BY JACK MACDONALD, EXECUTIVE VICE PRESIDENT

Mr. ASMUS. Mr. Chairman and members of the subcommittee, my name is Harry Asmus. I am the president of the National Council of Health Care Services which represents a select group of proprietary multifacility nursing home firms. Members of the national council own and/or administer more than 80,000 beds in long-term care facilities throughout the country.

We appreciate this opportunity to appear before you today and submit a brief statement concerning S. 1470. The national council commends you, Senator Talmadge and the committee members, for taking the initiative in this bill to correct, and hopefully reform, the medicare and medicaid programs.

We strongly support the intent of S. 1470 as reflected in the title of the bill, "Medicare and Medicaid Administrative and Reimbursement Reform Act." That title effectively delineates the two areas that are the cause of the major problems of the medicare and medicaid programs.

The present diffusion and confusion in the administration of the medicare and medicaid programs has created a regulatory quagmire that has prevented the effective operation of the two programs. It has also created problems in the enforcement of standards which, in many instances, have led to the abuses noted by various critics of the health industry. These problems involve eligibility criteria for beneficiaries, the delivery of services, certification of providers, and payment for services rendered under the program.

A more effective administration is required if this situation is to be corrected. This can only result, however, if a single authority has the

overall responsibility and accountability for determining the acceptable scope and levels of services and monitoring and assuring that the budgetary constraints are met for services rendered to beneficiaries.

Although one may argue that medicaid is significantly different from medicare because it is administered by the States, nevertheless, the States are administering the medicaid program under federally mandated regulations. These regulations presently leave the States with little flexibility once they have determined the beneficiary's eligibility and that individual's need for services under the medicaid program.

For these reasons, the proposed consolidation and restructuring of the responsible Federal agencies under a single authority, the Assistant Secretary for Health Care Financing as set forth in S. 1470 would greatly assist in resolving the confusion in the administration of the medicare and medicaid programs.

We are of the firm opinion that this type of massive restructuring of the administrative bureaucracy of HEW requires the "advice and consent" of the legislative process. Therefore, we firmly support section 20 in S. 1470. While there is a strong need to restructure the administrative system of the two programs, there is a counterbalancing need to stabilize the medicare and medicaid payment standards for long-term care providers. The changes made as a result of the Social Security Amendments of 1972, Public Law 92-603, need to be evaluated as to their impact before any major revisions, such as instituting percentage caps on revenues are made involving the skilled nursing and intermediate care facilities. Mr. Chairman, in our opinion, this can best be achieved under the format proposed by S. 1470.

Based on that view, the national council offers specific comments and recommendations concerning the following sections of S. 1470.

In our summary on page 3 of our statement with regard to section 2 criteria for determining reasonable cost of hospital services—it is our understanding that this section, as proposed in S. 1470, only pertains to hospitals. As a result, it would not preclude the use of medicaid payment systems for nursing home services which have been developed by States pursuant to section 249 of Public Law 92-603. These systems we feel should not be encumbered by the system outlined in section 2 of S. 1470 or the concept of revenue caps which has been introduced in other legislation currently pending in Congress.

It is our recommendation that the Secretary should be strongly encouraged to utilize section 249 of Public Law 92-603 as a means to develop "improved methods" for establishing prospective payment systems which contain costs for nursing home services for both the medicaid and medicare programs.

On pages 5 and 6 in our statement, section 3, payments to promote closing and conversion of underutilized facilities, the National Council would acknowledge the fact that there may be at the present time, an excess of hospital beds in some parts of the country. However, we are concerned with the possible long-range results of these sections of S. 1470.

It should be noted that the shifting of excess hospital beds to another purpose could easily result in an excess of beds in that latter area. At the same time, it might be necessary at a later date to switch the

hospital beds back to their original purpose which could result in a shortage in the alternative service area.

Senator DOLE. If I may interrupt there, do you represent any rural areas?

Mr. ASMUS. Yes. I personally am from Colorado.

Senator DOLE. Very small hospitals, that we think this section may be very helpful to?

Mr. ASMUS. In very remote areas—it would have to be very remote areas, Senator.

Senator DOLE. I understand the problem you raise. I just wonder what the alternatives may be in some of the small towns like Russell, Kans., where we have a very small hospital. I am not sure what the utilization rate is.

Mr. ASMUS. I would say it would have to be very remote areas where the hospitals are maybe 15 to 20 beds or less, and this is very remote.

On pages 6 and 7 of our statement, section 20, hospital providers for long-term care service. It is our understanding that this section would require parity in payments between free standing skilled nursing facilities and hospital skilled nursing units on the basis of "an average rate per patient-day paid for routine services." The National Council strongly endorses the payment provisions set forth in this section for the payment for skilled nursing services furnished by a hospital.

On page 8 and 9 of our statement, section 21, reimbursement rates under medicaid for skilled nursing facilities and intermediate care facilities, we strongly support this provision. It is our opinion that this section would clarify the intent to allow State medicaid agencies the discretionary authority to include a "reasonable profit" in cost-related payment systems and rates developed pursuant to section 249 of Public Law 92-603.

We would urge the committee to reaffirm its original intent of this subsection as expressed in the committee's report on the Social Security Amendments of 1972.

On page 10 and 11 of our statement, section 22, medicaid certification and approval of skilled nursing and intermediate care facilities, Mr. Chairman, the problem in the area of certification and enforcement of standards is not one of who should be certifying, inspecting, and enforcing, but rather one of unifying the standards and surveys under a single authority. There is presently no one authority empowered to say "yes" or "no" on a timely basis in response to a certification finding.

As a result, this process can often be dragged out for an extended period of time.

In regards to section 32, regulations of the Secretary, Mr. Chairman, this provision is long overdue. It would directly address the type of situation that has occurred under section 249 of Public Law 92-603 where the Department of HEW delayed implementing that section for 5½ years.

The lack of timely implementation of provisions of the Social Security Act has plagued the medicare and medicaid programs since their inception. The damage which has occurred as a direct result should not be underestimated.

On page 14 and 15 of our statement, section 46, rate of return on net equity for for-profit hospitals, we support the percentage change in the rate of return on net equity for proprietary hospitals and skilled

nursing facilities prescribed in this section. We do so in the context of the present medicare payment system in that we do not feel that medicare's current rate of return, after taxes, is competitive with that of other service industries.

Mr. Chairman, at this time we would like to express our concern about the manner in which professional standards review organizations have approached skilled nursing and intermediate care services and patients. It is not the type of a situation which this committee intended when it approved enabling legislation in the Social Security Amendments in 1972.

Very few PSRO's have implemented programs for skilled nursing and intermediate care patients, and very little functional guidance has been provided to the facilities in this regard.

As a result, rather than PSRO's functioning in a manner that would alleviate much of the confusion in the review of services and the need for them by patients, they have only added to the mysteries of the utilization and quality review process.

We would recommend that the committee consider an amendment to S. 1470 which first would clearly delineate the functional relationships of the PSRO's for both skilled nursing and intermediate care services under the medicare and medicaid programs. Second, we would urge that all other medical utilization review authorities established for purposes of the medicare and medicaid programs be immediately consolidated and assumed by the PSRO's.

Third, that it be specified that a PSRO's authority is related to the determination of the medical appropriateness of a given service and that the appropriate medicaid or medicare authority retains the ultimate jurisdiction over program eligibility criteria of their beneficiaries.

Mr. Chairman, while we feel there are problems in the manner in which PSRO's are functioning in the long-term care area, we do not support their piecemeal elimination. They can be effective and beneficial to everyone concerned, including the patient, provider, government and the public.

Mr. Chairman, in conclusion, again, we appreciate the initiative which you have taken in holding these hearings and shown by introducing S. 1470. The need for reforming the administrative structure of the Medicare and Medicaid programs is clear. The National Council of Health Care Services feels that S. 1470 represents a large step in that direction and on that basis, we concur with the scope of the reform proposed in the bill.

Thank you.

Senator TALMADGE. Thank you very much for your very constructive testimony, Mr. Asmus.

Do you have any questions, Senator Dole?

Senator DOLE. No. I think it is an excellent statement. You raised a number of good points; it is very helpful.

[The prepared statement of Mr. Asmus follows:]

STATEMENT OF HARRY ASMUS ON BEHALF OF THE NATIONAL COUNCIL OF HEALTH CARE SERVICES

The National Council commends Senator Talmadge and the Committee members for taking the initiative reflected in this bill to correct, and hopefully, reform

the Medicare and Medicaid programs. We strongly support the intent of S. 1470 as reflected in the title of the bill "Medicare-Medicaid Administrative and Reimbursement Reform Act". That title effectively delineates the two areas which are the cause of the major problems of the Medicare and Medicaid programs.

The present diffusion and confusion in the administration of the Medicare and Medicaid programs has created a regulatory quagmire which has prevented the effective operation of the two programs. It has also created problems in the enforcement of standards which in many instances have led to the abuses noted by various critics of the health industry.

These problems involve eligibility criteria for beneficiaries, the delivery of services, certification of providers, and payment for services rendered under the programs.

A more effective administration is required if this situation is to be corrected. This can only result, however, if a single authority has the overall responsibility and accountability for—

(1) determining the acceptable scope and levels of services, and

(2) monitoring and assuring that the budgetary constraints are met for services rendered to beneficiaries.

Though one might argue that Medicaid is significantly different from Medicare because it is administered by the States, nevertheless, the States are administering the Medicaid program under Federally mandated regulations. These regulations presently leave the States with little flexibility once they have determined the beneficiary's eligibility and that individual's need for services under the Medicaid program. For these reasons, the proposed consolidation and restructuring of the responsible Federal agencies under a single authority, the Assistant Secretary for Health Care Financing, as set forth in S. 1470, would greatly assist in resolving the confusion in the administration of the Medicare and Medicaid programs.

The National Council applauds the initiative shown by the Secretary of HEW, Joseph Califano in administratively establishing the "Health Care Financing Administration", this has, in effect, resulted in the conceptualized reorganization which is described in Section 30.

However, we are of the firm opinion that this type of massive restructuring of the administrative bureaucracy of HEW requires the "advice and consent" of the legislative process. Therefore, we firmly support Section 20 in S. 1470.

While there is a strong need to restructure the administration systems of the two programs, there is a counter-balancing need to stabilize the Medicare and Medicaid payment standards for long term care providers. The changes made as a result of the Social Security Amendments of 1972, Public Law 92-603, need to be evaluated as to their impact before any major revisions such as instituting percentage caps on revenues are made involving the skilled nursing and intermediate care facilities. Mr. Chairman, in our opinion, this can best be achieved under the format proposed by S. 1470.

Based on that view, the National Council offers specific comments and recommendations concerning the following sections of S. 1470.

SEC. 2. Criteria for determining reasonable cost of hospital services

It is our understanding that this section, as proposed in S. 1470, only pertains to hospitals. As a result, it would not preclude the use of Medicaid payment systems for nursing home services which have been developed by States pursuant to section 249 of Public Law 92-603. These systems we feel should not be encumbered by the system outlined in Section 2 of S. 1470 or the concept of revenue caps which has been introduced in other legislation currently pending in Congress.

It is our recommendation that the Secretary should be strongly encouraged to utilize section 249 of Public Law 92-603 as the means to develop "improved methods" for establishing prospective payment systems which contain costs for nursing home services for both the Medicaid and Medicare programs.

SEC. 3. Payments to promote closing and conversion of underutilized facilities

The National Council would acknowledge the fact that there may be, at the present time, an excess of hospital beds in some parts of the country. However, we are concerned with the possible long-range results of these sections of S. 1470.

It should be noted that the shifting of excess hospital beds to another purpose could easily result in an excess of beds in that latter area. At the same time, it might be necessary at a later date to switch the hospital beds back to their original purpose, which could result in a shortage in the alternative service area.

We would also point out that there is a difference in physical plant standards between hospitals and nursing homes. Nursing facilities are now being required to have more floor space available than hospitals for patients outside, as well as inside their rooms, for what the regulations define as general "activities of daily living".

It is, therefore, our recommendation that the Committee should carefully weigh and consider the possible ramifications of the conversion of excess hospital beds on other segments of the industry. To put it simply, we are concerned that the suggested cure might be worse than the disease.

SEC. 20. Hospital providers for long-term care services

It is our understanding that this section would require parity in payments between free standing skilled nursing facilities and hospital skilled nursing units on the basis of "an average rate per patient-day paid for routine services". The National Council strongly endorses the payment provisions set forth in this section for the payment for skilled nursing services furnished by a hospital.

SEC. 4. Federal participation in hospital capital expenditures

In regard to subsection (d) of this section we would like to call to the attention of the Committee the problems created by the interpretation and resulting regulations implementing the existing Section 1122 (g) of the Social Security Act. The Department of Health, Education, and Welfare issued regulation (42 CFR 100.103(a)(1)) on November 9, 1973, which require that the purchaser of an existing facility must obtain approval for that purchase from the appropriate comprehensive health planning agency.

We would urge the Committee to give consideration to clarifying the intent of the existing section as well as subsection (d) of S. 1470 in regard to the simple acquisition of existing facilities. We would urge that such simple acquisitions be exempted when there is no increase in the size of the facility or a change in the services which they provide.

SEC. 21. Reimbursement rates under Medicaid for skilled nursing facilities and intermediate care facilities

We strongly support this provision. It is our opinion that this section would clarify the intent to allow State Medicaid agencies the discretionary authority to include a "reasonable profit" in cost related payment systems and rates, developed pursuant to section 249 of Public Law 92-603.

We would also like to draw the Committee's attention to the fact that subsection (b) of section 249 of Public Law 92-603 has still not been implemented by the Department of Health, Education, and Welfare. Subsection (b) would provide an excellent opportunity to simplify the payment structure faced by nursing facilities participating in the Medicare and Medicaid program. This would be accomplished under subsection (b) in that the Secretary of HEW is permitted to utilize a State's Medicaid payment method developed in accordance with subsection (a) for purposes of the Medicare programs.

We would urge the Committee to reaffirm its original intent of this subsection as expressed in the Committee's "Report on Social Security Amendments of 1972".

SEC. 22. Medicaid certification and approval of skilled nursing and intermediate care facilities

Mr. Chairman, the problem in the area of certification and enforcement of standards is not one of who should be certifying, inspecting, and enforcing, but rather one of unifying the standards and surveys under a single authority. There is presently no one authority empowered to say "yes" or "no" on a timely basis in response to a certification finding. As a result, this process can often be dragged out for an extended period of time.

Based on our experience, this process can be accomplished most expeditiously at the local level. However, as the Committee is aware, this has in the past resulted in a general lack of uniformity in the application of standards in nursing facilities. Therefore, the consolidation of this authority in the Secretary may be appropriate. We would offer a word of caution though that this will require a very streamlined administrative process at the Federal level if we are to avoid a massive log jam of administrative delays in the certification process.

SEC. 23. Visits away from institution by patients of skilled nursing or intermediate care facilities

The concept reflected in this section is extremely important to both the nursing home patient and the facility. Patients should be encouraged to make visits to their families and not discouraged. The latter has been the practice, we are sorry to say, of the Department in the past. Even though they have recently liberalized their policy, we commend Senator Talmadge for clarifying the statute in regard to this issue.

SEC. 30. Establishment of Health Care Financing Administration

We support the proposed consolidation of agencies, as well as the administrative and policy responsibilities set forth by this section. An effective administration of the Federal Government's participation in the Medicare and Medicaid programs can only evolve if a single agency has the overall responsibility and authority to fully administer the programs. Anything less is both duplicative and cumbersome.

SEC. 31. State Medicaid Administration

We strongly endorse this section in that it clarifies the relationship between the State Medicaid agencies and the Federal Government. This is particularly true in regard to the areas of the accountability and the responsibility of the Medicaid program to patients and providers.

SEC. 32. Regulations of the Secretary

Mr. Chairman, this provision is long overdue. It would directly address the type of situation which has occurred under section 249 of Public Law 92-603 where the Department of Health, Education and Welfare delayed implementing that section for five-and-a-half years. The lack of timely implementation of provisions of the Social Security Act has plagued the Medicare and Medicaid programs since their inception. The damage which has occurred as a direct result should not be underestimated.

SEC. 33. Repeal of Section 1867

We would like to recommend that the Committee consider carefully the impact of this section which would abolish the Health Insurance Benefits Advisory Council. This proposal would cut off one of the few formal inputs that the public, as well as the health industry, have into the agencies which govern and regulate them.

While the Health Insurance Benefits Advisory Council has not always functioned effectively, it could be a valuable source in the formalization of objectives for the Department's Health programs. We urge the Committee to consider revising it in terms of possibly its membership makeup and its stated purpose, but not eliminating it at this time.

Sec. 46. Rate of return on net equity for for-profit hospitals

We support the percentage change in the rate of return on net equity for proprietary hospitals and skilled nursing facilities prescribed in this section.

We do so in the context of the present Medicare payment system, in that we do not feel Medicare's current rate of return, after taxes, is competitive with that of other service industries.

Senator TALMADGE. The committee will stand in recess until 8:30 tomorrow morning when we will hear from Bert Seidman, the AFL-CIO representative as the first witness; Raymond T. Holden, the chairman of the board of trustees of the American Medical Association; Anthony G. Weinlein, the secretary-treasurer of the Service Employees International Union; Neil Hollander, vice president for Health Care Services, Blue Cross Association; A. B. Davis, Jr., executive vice president, chairman of the board of directors, Kansas Hospital Association; Morton D. Miller, the vice chairman of Equitable Life Assurance Society of the United States; and Tom Greene III, vice president of Paine, Webber, Jackson & Curtis, Inc., on behalf of the Hospital Financing Study Group.

The committee will stand in recess until 8:30 a.m.

[Thereupon, at 10:30 a.m., the hearing in the above-entitled matter was recessed to reconvene at 8:30 a.m. on Thursday, June 9, 1977.]

MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT

THURSDAY, JUNE 9, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 8:30 a.m. in room 2221. Dirksen Senate Office Building, Hon. Herman Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Dole, and Danforth.

Senator TALMADGE. The subcommittee will please be in order.

The first witness this morning is Mr. Bert Seidman, director, Social Security Department, AFL-CIO. We are delighted to have you, Mr. Seidman. You may insert your full statement into the record and summarize it in 10 minutes.

STATEMENT OF BERT SEIDMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL-CIO; ACCOMPANIED BY ROBERT McGLOTTEN, LEGISLATIVE DEPARTMENT, AND RICHARD SHOEMAKER, SOCIAL SECURITY DEPARTMENT, AFL-CIO

Mr. SEIDMAN. Thank you, Mr. Chairman.

With me this morning are, to my left, Robert McGlotten, member of the legislative department of the AFL-CIO and to my right, Richard Shoemaker, member of the social security department of the AFL-CIO.

Senator TALMADGE. I am delighted to have your gentlemen.

Mr. SEIDMAN. The AFL-CIO appreciates the opportunity to appear before the Health Subcommittee with respect to the Medicare-Medicaid Administrative and Reimbursement Act.

Medical care costs continue to escalate at about twice the rate of all goods and services as measured by the Consumer Price Index. The impact of these rising costs on the Federal budget is substantial. In fiscal year 1976, 42 percent of health expenditures came from public funds. Federal payments for medicare, medicaid, and other health programs totaled about \$40 billion.

The combination of direct and indirect Federal, State, and local government payments to the health industry makes the health industry one of the most heavily subsidized industries in the country. This subsidy amounts to over \$64 billion.

There is no way to control these escalating costs until Congress enacts a comprehensive national health insurance program such as the health security bill (S. 3). Under health security the Congress would establish a budget for health services and provide the financial resources to pay for these services. Medical societies would be obligated to negotiate realistic fee schedules so that the budget for physician services could not be exceeded.

Likewise, hospitals and other health institutions would have to negotiate their budgets so that total expenditures for hospitalization could not exceed the amount of funds allocated for institutional care. A budgeting system of cost control is far more flexible than regulation and is less costly as well.

Over the long run, the health security program is the least costly of all national health insurance proposals that have been introduced into the Congress. Under health security, and only under health security, could health care costs be held to a constant percentage of the gross national product which is, currently, 8.6 percent of the GNP.

Other national health insurance bills split up the funding of NHI between the Government and the private sector. The private sector is divided between Blue Cross-Blue Shield and about 2,000 private insurance carriers. Under such proposals, the providers of health care would continue to dictate their remuneration. There would be no outside limits to the amount of money the health industry could absorb.

The bill introduced by the distinguished chairman of this subcommittee is a step in the right direction but does not go far enough. There are two main thrusts in the bill:

One, it would establish a single prospective reimbursement system for hospitals;

Two, it would attempt to induce physicians to accept usual and customary fees under medicare.

If a prospective hospital reimbursement program is to control hospital costs, it must deal with three elements: One, intensity of care; two, utilization; and three, routine operating costs.

Intensity of care is the primary cause of hospital cost inflation. Excessive utilization of hospital beds is the second most important cause of escalating costs. But S. 1470 deals only with routine operating costs which have contributed to only a minor degree to this inflation. We conclude, therefore, that S. 1470 will not significantly contain the escalation of hospital and medical care costs.

We find particularly objectionable the provisions of S. 1470 which would, in effect, establish a system of wage control. Hospital wages are too low in most communities and average less for the Nation as a whole than those of workers generally or even service workers. They have played almost no role in generating the inordinate escalation of hospital costs. Yet, S. 1470, in effect, would place a ceiling on hospital wages keeping them permanently below general wage levels. These provisions are unacceptable to us as an infringement of the rights of hospital workers to negotiate their wages with hospital management through the process of free collective bargaining.

We believe that a negotiated budget is a far more effective and flexible tool for controlling hospital costs than the complicated system pro-

vided in S. 1470. However, hospital budgets would have to be negotiated across-the-board and not just for patients covered by medicare and medicaid. Otherwise, costs could too readily be passed on to private patients whose premiums are paid by negotiated health benefit packages, group insurance, and individual health insurance policies.

The bill treats physicians very gently. Physicians would be induced to accept assignments by a possible \$2 per encounter increase in their income from medicare patients if they agreed to become participating physicians.

This simply will not work because nonparticipating physicians in the medicare program make more than \$2 extra per encounter from their over-65 patients.

The AFL-CIO strongly recommends a negotiated fee schedule for physicians. Such a fee schedule should be applied across-the-board and not just for medicare patients. In addition, physicians should be free to elect payment by capitation. It is quite possible that some physicians would prefer this method of reimbursement since it provides improved continuity of care for the patient and almost complete elimination of paperwork for the physician.

We strongly favor the provision in the bill which relieves HMO's of restrictions on reimbursement for expenses related to capital expenditures where the HMO can demonstrate that it can provide health services effectively and economically.

The AFL-CIO supports provisions of the bill which would place limits on cost reimbursement by medicare and medicaid to hospital-based physicians who have percentage or lease arrangements with the hospital. Radiologists, pathologists, and anesthesiologists have made excessive profits from such arrangements.

Additional recommendations with respect to detailed provisions of S. 1470 will be found in our complete statement.

In conclusion, we believe the most effective way in which to achieve control over escalating health care costs is to budget health expenditures for hospital and physician services along the lines of the health security bill.

For the interim period, we favor the approach of S. 1391, the administration's hospital cost containment provisions with, however, some important reservations with regard to wage control features which we have set forth in our attached statement. We are strongly convinced that Congress should not now enact a long-term program which might have to be dismantled when a national health insurance program is developed. Therefore, we urge that only a temporary cost containment bill be reported out to be effective until Congress has an opportunity to review the national health insurance proposal to be submitted to Congress by the administration early next year.

That completes the summary of my statement, Mr. Chairman. The details on many of these points, and others, are continued in the full statement and we have also attached to our statement a copy of a summary of a statement that we submitted to another committee with respect to the administration's proposal, the Hospital Costs Containment Act of 1977, S. 1391.

Senator TALMADGE. Thank you, Mr. Seidman. All of that will be inserted in the record.

I congratulate you on a very thoughtful statement. The subcommittee has given consideration to broadening the hospital reimbursement provision to extend beyond medicare and medicaid as you recommend.

Mr. Seidman, if the Congress does, in fact, enact a national health insurance bill, are you saying that the Federal Government should pay without limit whatever wage amounts employees can negotiate with hospitals?

Mr. SEIDMAN. We are saying two things, Mr. Chairman. In the first place, we are saying that there is no evidence whatsoever that wage increases in the hospital industry have played any significant role in the escalation, the tremendous escalation in hospital costs which has occurred, not just within the past few years, but over a long period of time.

I have a report of the Council on Wage and Price Stability which was prepared by Prof. Martin Feldstein of Harvard University. I might say, Mr. Chairman, that Professor Feldstein and we disagree on many points. He is not particularly a friend of organized labor. But in this report he makes it quite clear that the responsibility for the rise in hospital costs does not rest at all with increased wages. He says, "Although hospital wage rates have risen more rapidly than wages in other parts of the economy"—and there he happens to be wrong; we have a table in our testimony that shows that this is not true, nevertheless, this is what he says: "These relatively greater wage increases are responsible for only a small part of the overall increase in the cost of hospital care."

"Had earnings of hospital workers risen no faster than the average for all private, nonfarm production workers, the annual rate of increase in daily hospital costs would have been only about 1 percentage point lower." Which makes it quite clear, therefore, that even with his assumption, which is wrong, that hospital costs have risen faster than other wages—this may be true in percentage terms, but not in absolute terms.

The rise in hospital wages has had no appreciable impact on the rise in hospital costs.

Now, in addition to that, we see no evidence whatsoever that there is going to be any tremendous increase in hospital costs in either negotiated situations where collective bargaining between unions and management prevails or in other situations.

Therefore, we can see no reason for singling out this one sector of the economy with imposition of wage controls on relatively low-wage earners in this industry. We are opposed to wage controls in the economy. I believe most of the Members of Congress and the administration are, as well, and we see no reason for imposing it in this industry.

Senator TALMADGE. Is there any test of reasonableness that you can think of?

Mr. SEIDMAN. The test of reasonableness is the test that occurs in collective bargaining. Management has every incentive, particularly where there are any controls on cost, to hold down wages. They always do. The workers in this industry are not so well-organized that they can exact out of line wage increases and I have no reason to think that they will.

Therefore, I see no reason why there should be any ceiling on wage increases in this industry, when we all agree that this is not the route to go for in the economy as a whole and there is no reason why these workers should be singled out for that kind of discrimination.

Senator TALMADGE. You seem to support limits on hospital revenues and controls on payments for doctors, and at the same time urge a blank check for any or all wage increases in nonsupervisory hospital employees.

Mr. SEIDMAN. Mr. Chairman, we might have a more difficult position to uphold if, in fact, the increase in hospital wages had been largely responsible for the tremendous escalation of hospital costs. But this is not true at all. There is no reason to think that it would be.

We do think that there should be controls on those elements of hospital costs which have been responsible for the inflation in cost as well as other sectors of the health care economy that have been responsible. We see no evidence whatsoever that these workers, low-paid workers, have been responsible for this escalation. We see no reason why a ceiling should be placed on them when nobody that I know of is proposing to do anything similar in any other industry.

Senator TALMADGE. We were told yesterday by a witness that the wage levels of hospital employees have not risen significantly in the past and thus has not contributed significantly to the rise in hospital costs. You said substantially the same thing today.

What percentage have salaries risen generally for health care workers say in the last 5 or 6 years?

Mr. SEIDMAN. We have a table attached to our testimony, appendix A, which gives average hourly wages for nonsupervisory employees in hospitals. The latest year is 1976: \$4.18 as compared with \$4.36 for all service workers and \$4.87 for total private employees.

You can see how much lower hospital wages are on the average.

With respect to your question, 5 years earlier, 1971, when they were \$2.96—I cannot do the figures in my head, Mr. Chairman. We have some figures, however, in our table which do not deal specifically with the questions that you ask but they give you some idea of what has been happening. We think it is probable that wages have been rising somewhat higher in hospitals which have been organized by unions than in nonunion hospitals. We think that is the way it should be; that is why workers join unions. But even organized hospitals have been unable to keep up with the cost of living.

In 1975, the median negotiated wage increase amounted to 7.7 percent while the cost of living increased by 9.1 percent, and in 1976 the average negotiated increase amounted to 6.4 percent while the cost of living increased 5.8 percent.

If you take the 2-year period, 1975–76, there was a drop in real wages for hospital workers over that period.

Senator TALMADGE. I believe it was two compared with seven.

Mr. SEIDMAN. Yes.

Senator TALMADGE. Fifty to sixty percent, is that about right?

Mr. SEIDMAN. No. That would be about 40 percent. It is 2.96 to 4.18.

Senator TALMADGE. Is one of the problems that some hospitals have too many employees?

Mr. SEIDMAN. They may have too many employees in one sense; that is, that they have too many beds to begin with and they have patients who are in hospitals unnecessarily when they should be getting ambulatory care. Therefore, they may have too many employees because they have too many beds and patients in hospitals that should not be in hospitals.

This is a question of management and does not relate to the workers in any way.

Senator TALMADGE. Senator Dole?

Senator DOLE. I am sorry I missed the testimony; I was attending a breakfast for Kansas. I apologize.

Senator TALMADGE. Thank you very much, Mr. Seidman, for a very interesting statement.

[The prepared statement of Mr. Seidman follows:]

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO appreciates the opportunity to appear before this subcommittee today to present our views with respect to S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act introduced by the distinguished Chairman of this subcommittee.

The time is ripe for Congress to take action to control the unconscionable escalation in medical care costs. President Carter's health message to Congress estimated that medical care costs will be \$160 billion in 1977 and will amount to close to nine percent of the Gross National Product. Compare this to Canada which has a social insurance health program which provides for its entire population comprehensive benefits without any deductibles for only seven percent of its GNP. Canada's costs are lower because they have a single social insurance program rather than the fragmented private insurance we have in the United States.

The average cost per day of a hospital stay has been increasing at a rate of about double the rate of increase of the Consumer Price Index. According to the Council on Wage and Price Stability, the average per day of a hospital confinement was \$191 in September 1976. This represents an 18.4 percent increase over the same month in the previous year.

The impact of these escalating costs on the federal budget is substantial. In fiscal year 1976, 42 percent of health expenditures came from public funds. Federal, state and local government payments for health care totaled \$58.8 billion. Total federal payments for health care, including Veterans Administration and Department of Defense hospitals, construction and research, came to \$39.9 billion. State and local government outlays for health were \$19.0 billion and tax subsidies for health purposes amounted, conservatively, to \$5.6 billion. The combination of direct and indirect federal, state and local government payments to the health industry makes this one of the most heavily supported industries in the country. The total annual subsidy to this industry amounts to \$64.4 billion.

It is disturbing that in the ten years that have elapsed since Medicare and Medicaid were implemented, Congress has yet to take effective action to control health care costs. The AFL-CIO, therefore, congratulates you, Mr. Chairman, on your initiative in introducing S. 1470.

COMPREHENSIVE NATIONAL HEALTH INSURANCE

It is our opinion that there is no way to control these escalating costs until Congress enacts a comprehensive national health insurance program such as the Health Security Bill (S. 3) which channels all funds through a single government agency with the power to review hospital budgets and negotiate with them as to the amount of their total reimbursement. The give and take of such negotiations is far more flexible and effective than regulations. Similarly, medical societies should have the opportunity to negotiate fee schedules with the responsible government agency and doctors should be required to accept

negotiated fees in full payment for services rendered. Doctors could participate or not participate in the program, but nonparticipating physicians would have to confine their practices to the few wealthy patients who could afford to pay their excessive fees.

Briefly this is how the Health Security Bill (S. 3) would work. The Health Security Bill would establish a national health expenditures budget comprised of Social Security taxes earmarked for health matched by federal general revenues. The only way in which providers could increase their revenue faster than incomes of the population as a whole would be to come before the Senate Finance Committee and the House Ways and Means Committee and justify an increase in taxes. Thus, Congress would decide what percentage of the gross national product should be allocated for health care.

As it is now, the government, Blue Cross and insurance companies are simply issuing blank checks for the providers virtually to fill in as they please.

The budgeting of health expenditures as provided by Health Security would not alter the present ownership of hospitals or the private practice of medicine. The delivery of health services would remain in the private sector.

The national budget for health expenditures would be a set amount in any given year. This national budget would be allocated to health regions and in turn to health services areas. The allocation would be based primarily, on two factors:

Expenditures for the prior year adjusted for inflation and productivity;
The need for health services.

For example, for physician services over-doctored health service areas would receive a somewhat lower budget, on a per capita basis, than under-doctored areas, clearly an incentive for better geographical distribution of physicians. Similar considerations would apply to facilities.

Because of built-in cost controls in a budgeting system, detailed regulation is not needed to control costs. Essentially, providers would have far more freedom to experiment and innovate under a budgetary system than under a regulatory system. Moreover, the budget approach provides incentives for physicians to become involved in better organizational arrangements for the delivery of care.

In a budgeted system of cost control, due weight would be given to historical costs. That is, due weight would be given to the prevailing pattern of hospital and institutional charges. Due weight would also be given to current fees for physicians and other provider services. However, allocations for institutional and practitioner services would be adjusted to take into account the need of patients for medical care.

This is the approach of the Health Security Bill (S. 3).

It should be emphasized that these decisions with respect to the allocation of funds for health services would not be made unilaterally by the Federal government. The Health Security bill provides for the allocation of money in conformity with state and local planning. The Health Systems Agencies (HSAs), the State Health Planning and Development Agencies (SHPDAs) and the state advisory councils and the Statewide Health Coordinating Councils (SHCCs) have been organized under the National Health Planning and Resources Development Act of 1974. This law provides for consumer, governmental and provider participation in the planning process. Thus, decisions with respect to resource allocation would not be dictated by the federal government as is so often alleged by the opponents of Health Security.

HEALTH SECURITY LEAST COSTLY OF ALL NHI PROPOSALS

The escalating federal expenditures for health services should bring into perspective the cost of the Health Security Program. Health Security has been the object of a propaganda attack that it costs too much. The fact is that Health Security over the long haul would be the least expensive of all national health insurance proposals. With Health Security, the national health expenditures budget could be held at or below the present 8.6 percent of the Gross National Product. It should be noted that this year Canada enacted a law which will relate federal payments to the provinces for health services to a constant percentage of the Canadian GNP. Canada has put the providers of care on notice that Canada will pay seven percent of its GNP for health care and no more.

There is no question that the health industry can absorb virtually unlimited amounts of money. One unique aspect of medical care is the degree to which

physicians control the demand for health services. Yet, physicians seldom think about the cost of the care they engender.

After the first contact with the physician, which is initiated by the patient, the doctor establishes the patient's course of treatment. The doctor advises the patient when he or she should come back for a follow-up office visit—next week, in 10 days or next month. The doctor orders the lab tests and X-rays. If the doctor deems it advisable, he or she hospitalizes the patient and decides when the patient can be discharged. The doctor writes the prescription, usually for costly trade name drugs, and gives instructions to interns, residents and nurses.

Another unique aspect of medical care is that the training of a physician emphasizes that any medical expense is justified. Thus, marginal improvements in the quality of care, even if achieved at substantial cost, can always be supported.

S. 1470

Considering the magnitude of the problem, S. 1470 is a step in the right direction but it is our view that it does not go far enough. The bill's principal thrust is in two directions: Section 2 would establish a single prospective reimbursement system for hospitals; and Section 10 would attempt to induce physicians to accept usual and customary fees under Medicare.

There are numerous other provisions, but we propose to limit our comments to the following sections:

Section 4. Federal participation in hospital capital expenditures.

Section 12. Hospital-associated physicians.

Section 14. Payments on behalf of deceased individuals.

Section 22. Medicaid certification and approval of skilled nursing and intermediate care facilities.

Sec. 30. Establishment of Health Care Financing Administration.

Sec. 33. Repeal of Section 1867.

Sec. 44. Disclosure of aggregate payments to physicians.

Sec. 46. Rate of return on net equity for for-profit hospitals.

S. 1470 is a very complex bill which would essentially rely on detailed regulation. Its implementation would require a large number of investigators and enforcers. Unless sufficient funds were provided to police the providers there would, undoubtedly, be widespread evasion of its provisions.

HOSPITAL REIMBURSEMENT

The major thrust of the bill would be to establish an incentive reimbursement method rewarding hospitals whose routine operating costs are less than average and penalizing hospitals whose routine operating costs are more than 20 percent above average. While some high cost hospitals would have to become more efficient, or be phased out, the upward trend of average hospital costs would continue because the organization of hospital services would not be altered and the growth in utilization of new services and technology would continue unabated.

To be effective, a prospective hospital reimbursement scheme must deal with three elements: (1) intensity of care, (2) utilization and (3) routine operating costs. By focusing on only one of the above elements, such as routine operating costs, every hospital can too easily increase its revenues by expanding the other two elements.

The recent staff report of the Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs" shows that the intensity of care has been the primary cause of hospital cost inflation.

A study sponsored by the National Planning Association, "Technological Diffusion in the Hospital Sector" shows that intensive care units (ICUs) in hospitals were relatively rare in 1958 when nine percent of all community hospitals reported them. By 1974 virtually all hospitals with 200 or more beds reported having ICUs, 85 percent of those with 100-199 beds had them and 40 percent of those with fewer than 100 beds had them. We would suggest that the great majority of ICUs in hospitals with less than 200 beds are an unnecessary expense if they are within one hour of a medical center or large hospital by motor or air ambulance.

The study reported similar problems with respect to therapeutic radiation equipment and open heart surgery units. Not covered in the study is the proliferation of CAT (computerized axial tomography) scanners. No doubt the

CAT scanners are a useful diagnostic tool but must every hospital have one? Once purchased at a cost of \$300,000-\$500,000 they will have to be amortized.

It is important to recognize that new technology and new equipment is invariably purchased without evaluation as to their effectiveness. One study in Britain found that survival rates for heart attack victims were at least as good for patients cared for at home as for those who received intensive care.

Yet, we find very little in S. 1470 which addresses the problem of proliferation of medical technology which is never evaluated in terms of life saving potential nor cost effectiveness. In fact, S. 1470 would invite escalation of these costs.

In the first place, the bill relies on the health planning legislation to control capital expenditures. This legislation has been in effect for ten years now, and there is not a shred of evidence that planning has been able to control capital expenditures for new technology. With the passage of Public Law 93-641, Congress has given planning agencies new powers. Hopefully, these new powers will curtail such capital expenditures. However, we are skeptical. In the first place a minimum representation of providers on Health Systems Agencies Planning Bodies must be from 33 to 49 percent. Their pocketbooks are directly affected by planning decisions, but the pocketbooks of consumers are only indirectly and remotely affected by such decisions. At any given meeting, therefore, the majority of those in attendance will likely be providers.

Secondly, the ancillary service costs would continue to be uncontrolled so that medical technologists required for the operation of new equipment would be exempt from the prospective reimbursement provisions of S. 1470.

Third, section 2(aa)(4)(F) states: "If a hospital satisfactorily demonstrates to the Secretary that, in the aggregate, its patients require a substantially greater intensity of care than is generally provided by the other hospitals in the same category, resulting in unusually greater routine operating costs, then the adjusted per diem payment rate shall not apply to that portion of the hospital's routine operating costs attributed to the greater intensity of care required."

What patients require with respect to intensity of care is a medical decision and there is a community of interest between the medical staff and the hospital administrator with respect to increasing the intensity of care.

Fourth, the incentive reimbursement provisions of the bill specifically exclude "direct personnel and supply costs of hospital education and training programs" as well as the "costs of interns, residents and non-administrative physicians." Thus, there is an incentive for every hospital to institute, if it doesn't have one, an educational and training program.

It is our conclusion that S. 1470 would accelerate the trend to more and more intensive care—the primary cause for hospital cost inflation.

S. 1470 does not have any provision that would stop hospitals from increasing utilization, the second most important factor in controlling hospital costs. As we understand the bill, the Secretary would be required to establish a classification system for short-term general hospitals based on the number of beds in the hospital.

The "routine operating costs" of all the hospitals in each category would be averaged. This average cost would become the hospital's per diem payment rate for "routine operating costs" for services to patients covered by Medicare and Medicaid. After the per diem payment rate had been thus established, therefore, any increases in hospital utilization would result in lower costs and a larger surplus which would have to be shared with the government. This would be a built-in incentive for hospitals to increase utilization for Medicare and Medicaid patients. Thus utilization, the second largest factor responsible for rising hospital costs, would be encouraged.

Moreover, hospital administrators are not going to look favorably upon returning one-half of any savings back to the government. They would have, on the contrary, an incentive to increase the intensity of care by, for example, purchasing a CAT scanner or some other expensive equipment. Hospital administrators are in no position to resist the demands of the medical staff because their customers are doctors, not patients. The transfer of the affiliation of even one doctor to another hospital would result in a substantial loss in hospital revenues.

While S. 1470 does little to control the most inflationary elements of hospital costs, it would control the wages of hospital workers. It is the position of the AFL-CIO that the wages of nonsupervisory employees must be determined by free collective bargaining where such employees are organized.

The incentive reimbursement system applies only to routine operating costs such as the cost of supplies and food which are only marginally controllable by the hospital. The controllable items of routine operating costs, the wages of nurses, the wages of clerks and stenographers, the wages of janitors and engineers in the maintenance department, would be controlled by the bill. The costs of capital, costs of education and training, physician costs, energy costs, fuel costs, malpractice insurance expense and ancillary service costs (not defined) would continue to be reimbursed on a cost-plus basis under Medicare and Medicaid. In fairness, routine operating costs would include the salaries of management and supervisory personnel. However, we consider it highly unlikely that management would cut their salaries or even hold them constant. In our judgment, S. 1470 is not a cost containment bill. Rather, it is a wage control bill. No wonder the hospitals favor S. 1470 over the Administration's Bill, S. 1391.

Hospital wages still lag behind the average wages for all private nonsupervisory employees and even behind the average wages for service employees. In 1976, the average hourly earnings of nonsupervisory employees in all nonfarm employment amounted to \$4.87. For service employees, it was \$4.36 and for hospital workers only \$4.18. Assuming a full work-year of 2080 hours, the annual earnings of the average hospital worker would come to \$8694, substantially below the level of an austerity budget of \$10,041 for a family of four in an urban community. From 1968 to 1976 the wages of hospital employees increased by only \$1.87 while those of employees in service jobs increased by \$1.93 and of all nonsupervisory employees in private industry by \$2.02 even though it was during this period that hospital employees gained coverage under the Fair Labor Standards Act and for the first time large numbers of them were benefited by collective bargaining negotiations. (See Appendix A for the average hourly earnings for all private employment, all service employment and hospital employment from 1968 to 1976).

Collective bargaining settlements in the hospital industry have been modest. In 1975, the median bargained wage increase amounted to 7.7 percent. In that year, the cost-of-living rose 9.1 percent. Even organized hospitals were unable to keep up with the cost-of-living. In 1976, the average negotiated wage increase amounted to 6.4 percent while the cost-of-living increased 5.8 percent which still meant a drop in real wages over the two-year period.

The AFL-CIO unions with substantial membership in the hospital industry are the Service Employees International Union and the American Federation of State, County and Municipal Employees. These unions will be testifying in more detail with respect to wages in the hospital industry and with respect to their collective bargaining contracts.

The recent staff report of the Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs," clearly shows that hospital wages have only been a minor factor in escalating hospital costs. Total labor costs were the source of only about one-tenth of the annual increase in average costs per patient per day. According to the American Hospital Association, payroll expenses have steadily declined as a proportion of total hospital expense from 66 percent in 1962 to 51 percent in the last quarter of 1976. But AHA payroll data includes salaries of supervisory employees. The percent of hospital expenses represented by nonsupervisory employees is only 35 percent.

Thus, wage increases of nonsupervisory employees have almost no bearing on the runaway inflation in hospital costs.

The principal cause of hospital cost inflation is not wages but the control doctors exercise over the manpower and capital resources of the hospital. This control in voluntary hospitals is exercised without any accountability to either the hospital or to the public. The result is dual administration, poor planning, duplication of expensive and seldom used equipment and the purchase of new equipment the effectiveness of which is seldom evaluated.

Therefore, we find particularly objectionable Section 2(b)(aa)(3)(E) of the bill which, in effect, would establish a system of wage control. It would limit wages and salary increases for hospital employees, but not for doctors, in areas where wages and salaries are generally low. Paradoxically, in highly organized areas where wages were already at more adequate levels but where wages in some hospitals lagged behind the average, some hospital wages would be allowed to rise to the average wage level provided the hospitals were not in the high cost bracket. But high cost hospitals, at or close to, the 120 percent ceiling would not be able to raise the wages and salaries of their employees even if they were below the average in a given area. Where hospital wages are higher than the

average wage level, such as might happen in small communities where the only organized employees are hospital workers, the wages of hospitals would have to be lowered to the average wage after October, 1979. We find this is completely unacceptable and clearly inconsistent with the principles of free collective bargaining.

There are other difficulties. The average general wage levels are simply not available throughout the country. Nor are the average wage levels of hospital employees. The gathering of such information would run into millions of dollars. Moreover, even if it were possible to gather this data it would not be useful. It would be like trying to compare oranges and apples. The mix of skills in hospital employment is very different from the mix of skill in the general community.

Another weakness of the bill is that the reimbursement method would apply only to Medicare and Medicaid payments.

In our opinion the approach to hospital cost containment of the Administration's Bill, S. 1391, is far superior to that of S. 1470. S. 1391 establishes a ceiling on each hospital's total revenue. The result would be that each hospital would have to address itself to all three elements that cause hospital cost inflation, namely: (1) intensity of care, (2) utilization and (3) efficiency of operation. Although the cost constraints would be more effective each hospital would have more flexibility than under S. 1470. To hold to the estimated "cap" of an allowable nine percent increase in total revenues, a hospital could, for example, close down a seldom used open heart surgery unit, eliminate its intensive care unit, sell its seldom used high voltage radiation therapy unit or defer purchase of a CAT scanner provided, of course, such units and scanners were available in the community. The hospital could bring pressure to bear on its medical staff to reduce unnecessary utilization or increase the efficiency of its operation or even resist wage increases for their underpaid employees. All these options and more would be available to the hospital.

The Administration Bill, moreover, would only require a small staff to enforce its provisions. S. 1470, on the other hand, would require an army of investigators and volumes of regulations.

We do recognize that S. 1391 can only be a short-term solution to escalating hospital costs. The high cost inefficient hospital can increase revenues by nine percent—the same percentage increase that is allowed an efficient low-cost hospital. In short, inefficiency is rewarded and efficiency penalized. But all that is required is a short-term program. Our main objection to the Administration Bill is that it also attempts to control wages. (See Appendix B for the summary of our statement on S. 1391 before the Senate Resources Committee).

The Carter Administration plans to introduce a national health insurance bill by March 31, 1978. Whatever program the Administration proposes, it will have to deal with escalating medical care costs. We think the most effective and flexible cost containment measure would be a negotiated budget on a hospital by hospital basis. In any event, we are strongly convinced that Congress should not enact a long-term program which might have to be dismantled when the thrust of the Administration's national health insurance program becomes clear.

SEC. 10. Agreement by physicians to accept assignments

With respect to physician reimbursement, S. 1470 treats doctors very gently. Under the bill there would be "participating" physicians under the Medicare program. A participating physician would be one who agrees to accept assignments in full reimbursement for services to Medicare patients.

Participating physicians would be allowed to submit their claims on a simplified, multiple-listing basis rather than submitting individual claim forms. It is estimated that the simplified multiple-listing form would save \$1 in administrative expense which would be passed on to the participating physician. In addition, it is claimed that the simplified multiple-listing forms would also save the participating physician another \$1 in billing, collection and office paperwork costs and thereby result in an extra \$2 of income for the participating physician.

While we find the \$1 reduction in Medicare administrative costs creditable, the experience of the United Mine Workers of America with their simplified multiple-listing claim forms for their participating physicians indicates the doctor does not save anywhere near an additional \$1 in his office costs.

But even if participating doctors could save \$1 in their office expense by using simplified multiple-listing claim forms, this together with the extra \$1.00 allowed

by Medicare would come to an increase in income of \$2.00 per patient encounter for the participating physician. Most doctors who refuse to accept Medicare assignments charge more than \$2.00 over the usual and customary fee allowed by Medicare.

As an alternative to the bill's approach, we recommend a negotiated fee schedule in the various Medicare reimbursement areas for Part B of Medicare. Physicians should then be required to accept such fee schedules in full payment for services rendered. However, to be fully effective such fee schedules should be applied across-the-board, not just to Medicare. Otherwise physicians would likely raise their fees for private patients, thereby creating three levels of care: one level for private patients, another level for Medicare patients and a bottom level for Medicaid beneficiaries.

Physicians should also be free to select payment by capitation for patients who choose to receive all of their primary care from such physicians. Physicians who elect capitation as a method of reimbursement for their services might well discover that such a payment mechanism results in better continuity of care for the patient and almost no paperwork since a separate claim for each service is unnecessary.

The experience of HMOs has shown that capitation payments reverse the incentives of physicians. Under fee-for-service, doctors make more money for treating sick patients; and the sicker the patient, the more the doctor makes. Under capitation, doctors make more money if they keep their patients well.

Capitation is the way in which medical groups are generally reimbursed in prepaid group practice plans. This is the primary reason hospital use in such plans is two to two and one-half times lower than in fee-for-service reimbursement by Blue Cross-Blue Shield and commercial insurance plans.

We strongly support Section 4(d) (B) (2) which allows the Secretary to determine that an exclusion of expenses related to any capital expenditure by a Health Maintenance Organization which has demonstrated that it can provide health services economically and that such exclusion would discourage the operation or expansion of such HMO, then such expenses related to capital expenditures would, regardless of need, be allowed.

Section 12 of S. 1470 would not recognize for Medicare and Medicaid reimbursement purposes percentage or lease arrangements for radiologists, pathologists and anesthesiologists where such arrangements resulted in higher costs than if such specialists were employees of the hospital. We support this provision in the bill which would limit these arrangements.

We also are in favor of Section 14 which would permit payment by Medicare on the basis of a non-receipted bill for care directly to the legal representative of a deceased Medicare beneficiary but suggest this problem could better be handled by requiring all physicians to accept assignments for deceased Medicare beneficiaries.

The AFL-CIO strongly supports Section 22 of the bill which would make the Secretary of HEW the final certifying officer for skilled nursing and intermediate care facilities under both Medicare and Medicaid. Present law gives the Secretary this authority with respect to skilled nursing facilities participating under Medicare only, or both Medicare and Medicaid, but not where they participate only under Medicaid. Thus, substandard nursing homes have continued in operation by accepting only Medicaid patients.

We find Section 30 which establishes a Health Care Financing Administration by law redundant since the Secretary of HEW has already begun to reorganize the Department by establishing a Health Care Financing Administration.

Section 33 of S. 1470 would terminate the Health Insurance Benefits Advisory Council (HIBAC). The AFL-CIO deplores this provision. HIBAC does provide some measure of public accountability in the administration of Medicare and Medicaid and can make a major contribution to these programs. The advisory council should be continued.

We disagree, however, with Section 44 which would prohibit the release of the names of physicians who have been paid large amounts for treating Medicare patients. Admittedly, HEW has made some serious errors in releasing such information and such errors must be corrected in the future, but the public has the right to know what physicians are exploiting the program.

Section 46 of the bill increases the rate of return on net equity of for-profit hospitals and skilled nursing homes to two times the average rate of return on Social Security investment from the present one and one-half times. We feel this

is unconscionable since investigations by the Subcommittee on Long-Term Care of the Special Committee on Aging of the Senate have revealed deplorable and exploitive conditions in the for-profit nursing home industry. We oppose this provision.

In conclusion, Mr. Chairman, we believe the cost control provisions of Health Security—that is, a budgeting system for institutional services—would be the most effective way by which the escalation of hospital costs could be contained. Admittedly, such a control would best be carried out if all payments for health services were channelled through a single agency of government such as in Health Security.

In order for such a program to work, it is quite clear, in our opinion, that the budget review must encompass the hospital's total budget and not just that part of the institution's budget that would apply to Medicare and Medicaid beneficiaries. Caps on part of the hospital budget for federal and state beneficiaries would leave health care institutions free to raise charges to private patients. This merely shifts costs but does not contain them. The premium cost to collectively bargained health plans would increase, along with all other premiums, to cover any shortage of payments for Medicare and Medicaid beneficiaries.

For physicians, we would support negotiated fee schedules which should be accepted by doctors as full payment for services rendered. These fee schedules would also have to be applied across-the-board. Capitation payments should be an alternative method of reimbursement for those practitioners who elect this method of payment.

We hope the Health Subcommittee of the Senate Finance Committee will give consideration to our views and that only a temporary cost containment program along the lines of the Administration's proposal but embodying the changes we have suggested should be enacted until such time as the Administration has the opportunity to introduce a national health insurance bill next year.

APPENDIX A

AVERAGE HOURLY EARNINGS (NONSUPERVISORY EMPLOYEES)

	Total private	Service	Hospitals
1968.....	\$2.85	\$2.43	\$2.31
1969.....	3.04	2.61	2.57
1970.....	3.22	2.81	2.79
1971.....	3.43	3.01	2.96
1972.....	3.65	3.40	3.08
1973.....	3.92	3.46	3.22
1974.....	4.22	3.76	3.45
1975.....	4.54	4.06	3.83
1976.....	4.87	4.36	4.18
Dollar increase 1968-76.....	2.02	1.93	1.87

Source: Bureau of Labor Statistics.

APPENDIX B

SUMMARY OF STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS BEFORE THE SENATE HEALTH SUBCOMMITTEE OF THE HUMAN RESOURCES COMMITTEE, ON THE HOSPITAL COST CONTAINMENT ACT OF 1977—MAY 26, 1977

On behalf of the AFL-CIO we wish to express our appreciation for the opportunity to testify before the Subcommittee on Health on the Hospital Cost Containment Act of 1977 (S. 1391).

S. 1391 establishes a Federal program of hospital cost containment which is designed to place a ceiling on future increases in hospital costs. The average cost of a hospital stay has been increasing at about double the rate of the increase of the Consumer Price Index. Clearly, something must be done to contain the escalation in hospital costs.

The Administration's bill has some strengths and some weaknesses. One strength is its provisions to place a ceiling on total hospital revenues. This comprehensive approach would contain not only hospital charges but also ex-

cessive utilization of hospital beds and extravagant use of personnel and capital resources, some of which is of marginal value in diagnosing and curing disease.

However, a ceiling on hospital revenues can only be a short-term solution to the hospital cost escalation problem. As time goes on, any attempt to regulate a single industry to the exclusion of others tends to build up distortions and stresses with respect to the allocation of human and capital resources. The high cost inefficient hospital would receive the same nine percent increase in revenues as the low cost efficient hospital. Inefficiency would, therefore, be rewarded and efficiency would be penalized. Also, even if hospital costs are contained, S. 1391 does nothing about the escalation of doctor fees or the increasing costs of drugs, nursing home care and home health services. Voluntary hospitals will inevitably attempt to transfer their expensive patients on to the public hospitals in order to contain their costs.

We see no reason why big-city public general hospitals should be covered under the bill. Such hospitals are already under stringent municipal and county budget controls. In fact, these hospitals are underfunded.

A much more effective way in which to control hospital costs would be to phase-in the principles of the Health Security Bill (S. 3) introduced by the distinguished Chairman of this Subcommittee. Under this approach, the Health Security Board would be empowered to negotiate hospital budgets on a hospital-by-hospital basis. Such an approach would provide flexibility, equity and maximum adaptation to local circumstances.

The wages of nonsupervisory employees lag behind the wages of such employees in private industry generally and in the service industry. For this reason, the wages of hospital employees should be established through free collective bargaining and not be restrained by the hospital cost containment program. In recent years, the average wages of nonsupervisory employees in hospitals have risen less than nine percent annually and, therefore, pose no threat to the nine percent increase in hospital revenues which would be allowed by the bill.

The recent staff report of the Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs," clearly shows that hospital wages have only been a minor factor in escalating hospital costs. Total labor costs were the source of only about one-tenth of the annual increase in average costs per patient, per day. According to the American Hospital Association, payroll expenses have steadily declined as a proportion of total hospital expenses from 66 percent in 1962 to 51 percent in the last quarter of 1976. But AHA payroll data includes salaries of supervisory employees. The percent of hospital expenses represented by nonsupervisory employees is only 35 percent.

Thus, since wage increases of nonsupervisory employees have no bearing on the runaway inflation in hospital costs, we strongly urge the exclusion of the wages of nonsupervisory employees from the hospital's base accounting year for purposes of determining the allowable increase.

However, request for such exclusion should not be optional with the hospitals as is provided in Section 124 of S. 1391. This section purports to exempt nonsupervisory personnel wage increases from the hospital revenue limit. Instead, it provides an incentive for hospitals to continue to increase expenditures in those areas which have been most responsible for health care inflation. This loophole is provided by the optional nature of the recalculation of revenue limits as stated in Section 124. In short, if hospitals request a modification of their revenues to eliminate the effects of nonsupervisory wages, then nonlabor costs can only rise by the permissible limit (e.g., nine percent). If, on the other hand, a hospital does not request such a modification, then it is possible for nonlabor costs to rise by as much as 14 percent by shifting the burden of the program onto the shoulders of low-wage workers by not granting such workers any increases.

The example that is contained in our full statement illustrates the problem.

The solution to this flaw in the legislation is to require the Secretary to modify for all hospitals the inpatient hospital revenue limit to assure exclusion from the base of any wage increases of nonsupervisory employees.

This can readily be accomplished by dropping the language at the beginning of Section 124(a) which states:

"At the request of any hospital which is subject of the provisions of this title and which provides the data necessary for the required calculation."

A major problem with the bill is that it initially allows a minimum of six states to opt out of the federal hospital cost containment program and operate

their own program as long as such states meet the Federal criteria. However, the provisions in the Federal law which are designed to provide for free collective bargaining are not included as one of the requisites for such state administration. In addition, other states could opt out of the Federal program in future years thereby emasculating uniform and effective administration.

The AFL-CIO strongly favors a Federal program with uniform standards and uniform administration. If, however, states are allowed to administer their own program, one criterion that should be required of the states would be that they adopt the Federal standard which would exclude nonsupervisory wages from the cost containment formula. This is implied in President Carter's health message but it is not specifically included in the bill.

Highly objectionable to the AFL-CIO is the provision in the bill which provides that the Secretary of the Department of Health, Education and Welfare would have the authority to review but one aspect of the program—the provisions relating to wages—and subsequently be able to modify or eliminate the exclusion of nonsupervisory wages. It is the position of the AFL-CIO that the Secretary should report to the Congress as to how the entire program is working within eighteen months so that Congress can take whatever action it deems appropriate. S. 1391 cannot be more than a temporary program since the regulation of a single industry involves many complexities and potentially serious distortions. The entire program, therefore, should be reviewed by March 31, 1979.

The disclosure requirements of the bill are completely inadequate. As stated by AFL-CIO President George Meany, "for too long, hospitals have operated under a veil of secrecy despite the fact that tax dollars are a major source of hospital income. Taxpayers have a right to know how these funds are expended." Public disclosure of each hospital's total receipts, expenses, assets and liabilities should be required. Hospitals should disclose the salaries of all highly paid employees including their fringe benefits. Detailed conflict-of-interest statements should be required of highly paid administrators and hospital trustees. In particular, the total receipts of a hospital's pathology and radiology departments should be disclosed. If anesthesiologists, pathologists and radiologists bill separately for their services, all such physicians should disclose their gross and net incomes. Additional information that the public should know would be hospital charges and whether the hospital has a preadmission certification program, whether the hospital requires a second opinion for elective surgery and whether the hospital shares services with other hospitals to avoid duplication of services.

Voluntary nonprofit and for-profit hospitals should not be allowed to transfer their expensive and nonpaying patients onto the public hospitals. The provisions of S. 1391 intended to deal with this problem need to be strengthened.

The AFL-CIO favors the proposed limitation on hospital capital expenditures but would suggest prepaid group practice plans to be given a priority for such capital expenditures as HMO hospitals reduce the total need for hospital beds.

In conclusion, Mr. Chairman, we approve the basic thrust of this bill which would establish a ceiling on hospital cost increases but the burden of cost containment must not be borne by low-paid hospital employees. We strongly urge that the improvements we have suggested be incorporated into the final bill that is reported out and passed by the Senate.

Senator TALMADGE. All too often we do not give enough recognition to those outstanding Federal employees who do a really good job. The health staff of the Education and Public Welfare Division of the Congressional Research Service typifies what good public service should be. The health staff has just produced an outstanding document entitled "Health Care Expenditures and their Controls." In one place, we can find virtually all of the information necessary to evaluate the present health care picture in the country. I commend the publication to all those interested in health care and its financing.

I ask, without objection, that the document be made a part of the record at this point.*

*See app. B, p. 588.

The next witness is Dr. Raymond T. Holden, chairman of the Board of Trustees of the American Medical Association; accompanied by, Edgar T. Beddingfield, Jr., chairman, council on legislation.

We are delighted to have you gentlemen. You may insert your statement in the record in full and summarize in 10 minutes, if you will.

STATEMENT OF RAYMOND T. HOLDEN, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY EDGAR T. BEDDINGFIELD, JR., M.D., CHAIRMAN, COUNCIL ON LEGISLATION

Dr. HOLDEN. Mr. Chairman, Senator Dole, we are pleased to present to this subcommittee the views of the American Medical Association on the important legislation, S. 1470, before you.

We have reviewed S. 1470 extensively and we commend the sponsors of this legislation for its broad coverage of a variety of issues in the medicare and medicaid programs. While we find that there are some provisions that we do not support, there are many others which we believe would be beneficial and for which we urge your favorable consideration.

One of the initial issues addressed in the bill relates to hospital costs. The intent of the hospital cost provisions is to provide a mechanism for controlling rising hospital costs. In any approach to this problem, it is important that solutions are not imposed that will adversely affect the quality of care available to beneficiaries of the Federal programs. As a matter of fact, it is important to note that attempts to curtail costs in those programs do in fact have a direct and substantial spill-over effect upon all patients.

It is important that any cost containment measures be equitable for institutions, for patients and for third party payers while at the same time not compromising essential and desirable services and allowing for continued advances in hospital services incorporating the latest in technological developments.

One approach, Mr. Chairman, that of the administration, would impose an arbitrary ceiling or "cap" on total hospital revenues. We have opposed this approach because we feel it lacks appropriate flexibility, provides disincentives for efficiency and in fact would reward inefficiency. Most importantly that proposal would impact unfavorably most directly upon the continued provision of quality care.

On the other hand, S. 1470 contains provisions which attempt to meet the hospital cost problem in a more positive and equitable manner. Mr. Chairman, notwithstanding our belief that S. 1470 is a more realistic program, we also believe that adoption of the program in the manner presently proposed could have uncertain and perhaps even undesirable effects. Risks of any single new program imposed nationally are not warranted at this time especially when there are other potential alternatives which merit similar consideration. Experiments with various reimbursement methods have not been fully implemented and evaluated.

We would recommend that the cost containment incentive program of S. 1470 be the subject of experiment and demonstration in a limited

geographic area before being considered for nationwide application. We feel that all interested parties would benefit from such a procedure.

Another provision addresses hospital costs by encouraging the voluntary elimination of underutilized beds and the closing of facilities or parts thereof. We think this approach in the bill can be beneficial and we support this. We do raise a question as to whether the supporting funds should be taken from patient care funds. This is one of the questions which need to be determined, and the fact that a new program has uncertainties emphasizes the advantages to be gained by initiating the program on a limited or experimental basis, as is the case here.

Mr. Chairman, we also have recognized the problem of increasing health costs and are seeking solutions. I wish I could tell you now that we have the answers, but we do not. The problems are complex as you know, and we do not believe anybody has complete answers. In an attempt to find solutions, however, we have established our national commission on the costs of medical care. That commission is broadly based and draws its membership from leadership of all sectors: Economics, government, labor, insurance, business, and the public. That commission, which has been meeting since early last year, has been charged with the responsibility to provide the AMA's Board of Trustees with a final report by January 1978, to contain:

One, a description of the health care delivery system;

Two, identification of the factors underlying the rising costs of medical care;

Three, a review and evaluation of existing research of the causes of medical care cost inflation;

Four, an evaluation of the impact of pending or future health care programs on the health care delivery system and medical care costs;

Five, recommendations on policies that will contribute to containment of medical expenditures while providing quality medical care to the public; and

Six, recommendations and direction for future research programs.

We note, also, that many State medical societies have expressed their concern about rising costs. Some are participating in the formation of local cost commissions.

Now, Mr. Chairman, Dr. Beddingfield will continue with our presentation.

DR. BEDDINGFIELD. Mr. Chairman, among the changes proposed in S. 1470, there are several applying to physician reimbursement that we believe could have a detrimental effect on the availability and quality of care under these programs.

The first relates to the creation of a special class of practitioners, designated "participating physicians," and we note the beneficial change made in this provision from the earlier provision in S. 3205. Nevertheless, "participating physicians" would still be those who agreed to accept all medicare reimbursement for their services on the basis of assignments. Inducements, such as simplified claims procedures and an "administrative cost savings allowance" of \$1 per patient, would be offered to encourage physicians to become "participating physicians."

This proposal is designed to increase the assignment rate by physicians, yet it does not reach the issue of why assignments are not widely accepted. The major deterrent to assignments is the insufficient reimbursement rate under medicare and this proposal does not correct this problem.

Increasing the acceptance of assignments can only be achieved by raising the level of reimbursement to reflect accurately the costs of the service provided. By perpetuating arbitrarily low reimbursement, physician acceptance of assignment in the medicare program will be discouraged. This can only lead to a reduction in the availability of care to the intended beneficiaries.

If simplified billing procedures can be made available, and we think they can be even without legislation, they should be introduced into the program now and be available to all physicians. It is disheartening to think that administrative aids might be available but are not used. Mr. Chairman, section 10 should be deleted.

Our second area of concern relates to the proposed criteria for determining medicare reasonable charges for physicians' services. Under section 11 of S. 1470, the Secretary would determine statewide prevailing charge levels for each State, based on 50 percent of the charges made for similar services in the State. Prevailing charge levels in a locality would continue to be subject to an economic index, but any increase in the prevailing charge level could not exceed the statewide prevailing charge by more than one-third.

The real effect of this change would be a further restriction on reimbursement levels in the State achieved primarily through a reduction in the already limited increases which would otherwise be allowed under the medicare economic index. We believe that this stifling of proper fee recognition for all physicians would be detrimental to maintaining a proper level of care under the program. This limitation could further aggravate the shifting to program beneficiaries and to private patients of those expenses which should be reimbursed by medicare. Section 11 should not be adopted.

S. 1470 also limits certain physician/hospital arrangements in a manner which we believe would also be detrimental to quality patient care. Those provisions in sections 12 and 40 should not be adopted.

Another area of concern relates to the redefinition of "physician's services" which would exclude those services the physician performs as an educator, an executive, or a researcher and would exclude even patient care services unless "personally performed by or personally directed by a physician" for the benefit of the patient and unless the service is of such a nature that its performance "by a physician is customary and appropriate." This new limitation would apply to all physicians' services under medicare.

We object strongly to this modification. All activities of physicians customarily recognized as part of the physicians' practice should be reimbursable as "physicians' services." A strict application of this language would have dire consequences for proper recognition of, and payment for, all services of physicians under medicare and would attempt to allow HEW to determine what the practice of medicine is. In fact, other provisions of this same section specifically and, in our

opinion, inappropriately delineate specific specialty practice for purposes of medicare. Section 12 should not be adopted.

S. 1470 would also authorize the development by HEW of a system of uniform procedural terminology and of a relative value schedule. We believe this provision is laudable in recognizing and attempting to ameliorate unfavorable restrictions upon the use of such schedules.

The RVS, as a guide to recognizing reimbursement, is a beneficial tool when developed by physicians for use in a locality. Several physicians' organizations in fact have sought to develop and use a RVS but have been prevented from doing so by Federal restrictions.

While the RVS as found in S. 1470 attempts to overcome restrictions, we believe it would do so in an undesirable manner. For example, the provision would not recognize any schedule unless developed and approved by the Secretary; medical organization participation is limited; adoption of the RVS by the Secretary would require use only in Federal programs and use in nonfederal programs would be approved but only of that RVS as used in Federal programs and approved by the Secretary. Any RVS would be subject to modification by the Secretary at any time, and there is no requirement that any RVS even be developed. We believe that this provision in S. 1470 is too restrictive. It could lead to increasing difficulty of beneficiaries in obtaining quality care.

As to its provision for developing and establishing a uniform procedural terminology, we believe this too is restrictive and does not properly recognize the widespread acceptability of the system adopted by the profession—current procedural terminology (CPT). Legislation should recognize and provide for use of terminology and relative value schedules as developed by the profession.

Section 15 should be modified to reflect our comments.

A number of proposed amendments are, in our opinion, necessary and proper as changes in medicare-medicaid. Among these are the payment under part B of medicare for certain antigens prepared by an allergist; allowing a return on equity for proprietary hospitals; facilitating payment after the death of a medicare beneficiary for services furnished; and allowing a profit factor under medicaid for skilled nursing and intermediate care facilities.

We are also pleased to see changes that would allow certain rural hospitals to be reimbursed under medicare for the provision of extended care services through the use of inpatient hospital facilities. Patient absences would also be allowed from skilled nursing or intermediate care facilities—allowing flexibility in treatment of extended care patients.

Changes in medicaid administration to allow more timely payment are also salutary. Other beneficial changes relate to reimbursement for ambulance services under medicare and to permissible cost-sharing under medicaid law. We are also gratified to see that restrictions would be placed on the release of confidential financial information on physicians under medicare and medicaid programs.

Notwithstanding these needed changes, the overall thrust of S. 1470 is cost control through curtailment of reimbursement. We again remind the committee that a lowering of reimbursement levels represents

cost savings only to the Government. The actual cost of services does not change, and the difference between actual cost and reimbursed cost usually is made up by higher prices on services to nongovernment patients or in increased cost to the program beneficiary.

It is unrealistic to expect that physicians and institutions can provide services to Federal beneficiaries within the mainstream of medical care if continually reimbursed at inadequate levels.

Mr. Chairman, at this time, we would be pleased to respond to questions from the subcommittee.

Senator TALMADGE. Thank you very much, gentlemen, for a very thoughtful statement.

As you may know, we have had constructive discussions with the college of pathologists concerning alternatives to percentage arrangements. The AMA statement, on page 19, still argues for retention of the percentage arrangements by hospital-paid specialists. You are chairman of the council on legislation. It is not true that the council on legislation has twice voted in the last 3 months, both times by 8 to 1, recommending that the AMA adopt a policy opposing the percentage arrangements?

Dr. BEDDINGFIELD. That statement is not totally accurate. Let me amplify it, if I may; in general, it is an accurate statement.

I think you have to consider the structure of the American Medical Association and the development of its policies. The governing body that sets policies for the AMA is a house of delegates, where the doctor members are elected democratically from the various States on the basis of physician representation. That body convenes at least twice a year to determine the association policy.

The interim governing authority is the board of trustees, chaired by Dr. Holden. There is a system of committees in the AMA, one of which is the council on legislation, which I do chair.

The council on legislation acts in an advisory capacity to the board of trustees and to the house of delegates. Any action that we take does not become association policy until it is favorably acted upon by the board of trustees or house of delegates. In fact, I am reminded very much of the similarity between this great deliberative body here. I understand occasionally recommendations come from the committees of the Senate that are changed somewhat when they get before the entire deliberative body.

The council on legislation has made a continuing study on the issues raised in the medicare and medicaid programs; certainly percentage contracts are one of them. We have made recommendations to the board.

We have appeared before the board. We have discussed this with legal counsel.

We believe that the thrust of this is not so much the structure of payment—whether it is a contract, a percentage contract, a fee for service type thing, the type of revision suggested in your previous bill—what is important is the bottom line, and we have reason to believe now that there are many hospitals, many physicians, many hospital boards of trustees who are perfectly happy with the existing contracts. We do not believe that anybody ought to profit exorbitantly, unnecessarily, off of any type of percentage arrangement.

It is the results that count, not the form that enables you to arrive at those results.

The matter is under continuing study. As a matter of fact, our board of trustees has recently taken some firm action which will be submitted to our ultimate governing body, the house of delegates, later this month in San Francisco which speaks to this issue.

Senator TALMADGE. Your council has recommended against it?

Dr. BEDDINGFIELD. We have submitted recommendations. We have discussed this with the board. It has been sent back to the council. It is under continuing study.

Senator TALMADGE. My question is for Dr. Holden. I recognize that the cost of medical practice increased significantly in the past few years. Are doctors' incomes before taxes declining as a result?

Dr. HOLDEN. Off the top of my head, Mr. Chairman, I would have to say I do not believe so.

Senator TALMADGE. Could you submit a more complete answer for the record?

Dr. HOLDEN. I could not give you a dollar and cents figure on that.

Senator TALMADGE. Do you have any information?

Dr. HOLDEN. If you wish we can submit a written answer.

Senator TALMADGE. I would be delighted. What I would like for you to do, if you can, is submit to this committee any information you can provide as to changes in physicians' pretax income by specialty, urban or rural location, time in practice, over, say the last 5 or 10 years.

Dr. HOLDEN. We will be glad to see that this information is given to the committee.

[The following was subsequently received for the record:]

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., July 6, 1977.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: Enclosed please find a series of tables showing physicians' net income after expenses from 1970-1974, the latest years for which our figures have been compiled. This information is collected by the AMA's Center for Health Services Research and Development through periodic surveys of physicians.

Net income from medical practice depends on various factors, fees being only one of these. Besides the fees charged by physicians, net income depends upon the quantity of services provided and the expenses incurred in delivering the services. Increases in fees or the quantity of services provided do not, in themselves, ensure that physicians will realize higher net incomes if the costs of conducting medical practice rise more rapidly than either fees or quantity of services provided, or both.

Variations in net income and expenses among specialties and geographical regions cannot be explained on the basis of simple generalizations. The nature of medical practice, control of expenses, regional wage and price levels, and a number of independent factors undoubtedly help to explain the relative levels of expense incurred in the conduct of medical practice. Similarly, the demand for varying services and additional independent factors must be considered in any explanation of net income variations. The data presented here should demonstrate the diversities inherent in any profile of physicians' net income and expenses.

Please contact us if we may be of further service to the Subcommittee. We request that this data be made part of the hearings records.

Sincerely,

JAMES H. SAMMONS, M.D.

Enclosures.

TABLE 1.—AVERAGE NET INCOME FROM MEDICAL PRACTICE BY SPECIALTY, 1970-74

Specialty	1970	1971	1972	1973	1974
Total-----	\$41,789	\$45,278	\$47,240	\$48,574	\$51,997
General practice-----	33,859	39,823	41,277	41,915	44,727
Internal medicine-----	40,251	42,869	44,692	47,809	51,390
Surgery-----	50,701	54,045	56,041	57,228	60,510
Pediatrics-----	34,799	38,503	38,879	41,166	42,112
Obstetrics-gynecology-----	47,904	54,045	53,165	55,357	61,693
Psychiatry-----	39,986	37,248	39,124	38,536	41,258
Anesthesiology-----	39,432	47,293	49,536	48,092	54,366

TABLE 3.—AVERAGE NET INCOME BY CENSUS DIVISION, 1970-74

Census division	1970	1971	1972	1973	1974
New England.....	\$38, 019	\$41, 925	\$43, 460	\$44, 215	\$46, 261
Middle Atlantic.....	37, 618	40, 510	43, 229	43, 815	47, 688
East North Central.....	47, 000	48, 232	49, 400	50, 509	54, 166
West North Central.....	41, 057	44, 987	46, 004	51, 541	53, 637
South Atlantic.....	42, 577	46, 782	48, 088	50, 316	54, 396
East South Central.....	41, 963	51, 084	53, 910	53, 317	58, 371
West South Central.....	43, 457	47, 162	49, 548	52, 758	57, 724
Mountain.....	39, 359	40, 291	43, 095	47, 371	49, 522
Pacific.....	44, 049	46, 813	49, 076	48, 132	50, 858

Senator TALMADGE. One other question, Dr. Holden.

The participating physician concept has been used in many Blue Shield plans—there is nothing new or radical about it.

You are opposed to this provision because you say that nothing less than increases in reimbursement levels would encourage acceptance of assignments.

Based upon discussions with many physicians, we believe that the provision will, in fact, increase their net incomes without necessarily increasing the payment levels. My bill of last year, as you know, S. 4205, contained a section requiring that medicaid pay not less than 80 percent of medicare payment levels for physicians' services. That provision would have established a minimum level. You opposed that section in your testimony last year, yet many physicians and physician organizations have since expressed their surprise at your position. In fact, they stated adoption of last year's provision would have resulted in substantial increases in payments under medicaid in many States and would increase physician's participation.

I think your position on the participating physician provision in this year's bill may also misread the intentions and concerns of many doctors. Would you comment on that?

Dr. HOLDEN. May I ask Dr. Beddingfield, who has been more conversant with the details of this bill, to comment?

Senator TALMADGE. Yes.

Dr. BEDDINGFIELD. Mr. Chairman, as we point out in our statement, we think that the present bill certainly represents a considerable improvement. The reason that we oppose the tying together of medicare and medicaid reimbursement in the last bill was that we realized the intent of the author of the legislation in trying to establish this as a floor for medicaid reimbursement and encourage participation by physicians. We have the feeling, and I think that this is a valid concern, that this would actually become a ceiling.

There is already a reduction in all governmental programs. First of all, you have the somewhat skewed definition of what the usual, customary and reasonable was, as in the original medicare law. That has been further curtailed by the imposition of the economic index.

Now there is a proposal in the bill to further regulate this by the mechanism in the present bill which would tend, over the long run, to equate fees, or narrow the gap between various fee areas.

Actually, I believe in the previous legislation that one really had two choices under medicare. You either participated as a physician, or you were a nonparticipating physician. You had to be either way, one way or the other.

If my reading of the present bill is correct, there is a third option. At the present time, one could be participating and be so identified with the Government stamp of approval as a participating physician, or one could be completely nonparticipating and bill all of his patients directly, or one could be selective, as one can now. One can take assignments in certain cases and not take assignments in other cases.

If you were following that last option, the dual choice mechanism, of course, I do not think you would be eligible for the dollars administratively.

Senator TALMADGE. Is it not true that under present law, they can do whatever they see fit? In many States, they have been reducing physician fees. In my own State, the prevailing rate now is 55 percent.

Dr. BEDDINGFIELD. Yes; I think we are all aware of not only the financial plight of the Federal Government, but of the States and the escalating medicaid costs. We share those concerns as recently as yesterday in my own State of North Carolina the Governor came out expressing his concerns about the medicaid program. There are going to be cutbacks in services or rates of reimbursement.

This is true.

Senator TALMADGE. Senator Dole?

Senator DOLE. Of course, you address yourself primarily to the chairman's legislation, which others cosponsored, S. 1470. You did not touch on the administration's proposal.

We should not infer that you support it because it was not mentioned, or should we?

Dr. BEDDINGFIELD. You are correct. We do not support the administration's proposal. We would be pleased to make available to this committee some prior testimony we have given to committees of the Congress on that proposal.

Senator DOLE. Even though there may be some objectionable features in S. 1470, that does offer a better framework as far as you are concerned?

Dr. BEDDINGFIELD. I think it is a better approach, very much so.

Senator DOLE. We have had a lot of testimony, from hospital witnesses and others, that really sort of keys in on the physicians. He is the key person, he or she, as far as costs are concerned, and the level of result of costs, because he sends you to the hospital, orders your services. A lot of the costs are a direct result of initiatives taken by the physician.

I am just wondering what can be done, or what is being done, or what should be done, to build a greater cost consciousness on the part of physicians?

I assume they might have that in mind from time to time, but you have the ball now. What do you do with it?

Dr. BEDDINGFIELD. I would be pleased to respond, Senator. Everybody wants a whipping boy. At this moment, we are the whipping boy.

Certainly, physicians do play a part in this. We are not trying to escape that role. I do not believe that thoughtless admission of patients to hospitals, or careless or prolific ordering of tests is playing a substantial part in the monumental problem facing us. It is a part of the problem.

We are concerned about costs as a professional organization, as practicing physicians—Dr. Holden made reference to a study going on currently in the AMA in which a Member of Congress is participating.

Second, to be more specific, the association has appeared before this committee back during the days of deliberation of PSRO, and we have PSRO. This is a mechanism which, when properly used, can address the problem that you are addressing in your question.

Ever since Congress created PSRO, the implementation of it has been slow—primarily because of the slowness of funding by Congress. The application of PSRO techniques is not universal across the land. Many of them exist only on paper and not in substance or function.

While we do not believe that cost control should be the primary and only thrust of PSRO, this was certainly a part of the motivation of the Congress in enacting that amendment to the Social Security Act. We believe that application of this technique, in looking at its results, would address the question as far as unnecessary admissions are concerned and as far as the appropriateness of various tests. Coming back, however, to what I consider to be the main difficulties—the main things causing the increase in health care costs—I believe they are inflation in general: the increasing expense of an advanced technology, the expectations of the public in general, and the over-expectations of the consuming public in general which, I think, have been engendered by overpromise by the Congress and perhaps even overexpectations engendered by the medical profession. We can do everything for you—the simple fact is, we cannot.

Senator DOLE. It seems to me that there is a lot of focus—not intentional—but repeated references to, we do not put anybody in the hospital, we do not this—it sort of rests on the doorstep of the physician. Sooner or later it is just going to occur to someone, if you just can control the physician you can control everything else. Probably it has already occurred to some.

Dr. BEDDINGFIELD. That thought has already occurred to me.

Senator DOLE. I am sure it has occurred to some of us in Congress.

Also in your statement you refer to the need for higher reimbursement by medicare. I am not certain I really understand what higher reimbursement is.

Let me give you an example. Is the reasonable amount \$1,000 for cataract surgery which medicare allows in New York, or Los Angeles or the \$800 that pays for the same procedure in San Francisco or the \$600 allowance in Boston, St. Louis, Phoenix, and Philadelphia? I am not certain what it is in Wilson, N.C., or Washington, D.C. I do not think it would be that much.

You have the same spread between the highs and the lows and the mediums as far as initial comprehensive office visits in Los Angeles and Chicago, \$60; \$50 in San Francisco; \$40 in New York, Philadelphia, Boston, Houston, Dallas, and Cleveland.

It is confusing. How should we determine what should be higher reimbursement?

Dr. BEDDINGFIELD. To further confuse it, giving a nuts and bolts example with which I am obviously more familiar, I can tell you a

\$10 an hour office visit in Wilson, N.C., is reimbursed at \$6.50 by medicaid. There are more of those office visits than there are of those \$1,000 cataract operations.

I would have to look into the technical aspects of the fees, because I am not, off the top of my head, that conversant. Your recitation of them sounds adequate by my standards, I think.

Senator DOLE. The \$600 or the \$1,000 is adequate?

Dr. BEDDINGFIELD. You have to look at the way these are traditionally developed, on the basis of the statistical measurement of the usual, customary, prevailing or reasonable profile and the application of the 75th percentile.

There were fees charged that were over that and picked up by the process to start with.

Senator DOLE. Mr. Chairman, I would ask to be made a part of the record this chart that does give some of the disparities or some of the comparisons.

Senator TALMADGE. Without objection, it will be inserted in the record.

[The material to be furnished follows:]

FISCAL YEAR 1976 PREVAILINGS FOR SELECTED PROCEDURES¹

20 largest cities	a	b	c	d	e	f	g	h
New York:								
a.....	40.00	23.60	50.00	25.00	1,200.00	1,000.00	1,040.00	1,000.00
b.....	30.00	16.00	38.00	20.00	1,000.00	800.00	844.25	850.00
c.....	35.00	15.00	41.30	17.70	884.30	707.40	825.00	800.00
Chicago.....	59.00	11.80	59.00	15.00	707.40	600.00	650.00	600.00
Los Angeles:								
a.....	59.00	15.00	59.00	15.00	1,002.00	795.80	1,000.00	1,000.00
b.....	60.00	12.00	60.00	15.00	810.00	707.40	980.00	875.00
c.....	52.50	12.00	61.90	15.00	850.00	652.50	940.00	800.00
d.....	59.00	15.00	60.00	15.00	1,000.00	768.50	1,000.00	1,000.00
Philadelphia:								
a.....	40.00	11.00	50.00	11.80	589.50	471.60	589.50	550.00
b.....	40.00	10.00	50.00	10.00	550.00	412.70	550.00	530.60
Detroit.....	45.00	11.00	50.00	12.10	600.00	471.60	550.00	575.00
Houston.....	40.00	11.80	50.00	11.80	707.40	589.50	600.00	630.00
Baltimore.....	50.00	10.00	50.00	12.00	589.50	450.00	589.50	589.50
Dallas.....	40.00	11.80	45.00	12.00	750.00	550.00	589.50	548.20
District of Columbia.....	47.20	11.80	59.00	14.20	589.50	483.40	710.00	619.00
Cleveland.....	40.00	11.80	40.00	11.00	500.00	450.00	530.60	550.00
Indianapolis.....	41.00	11.00	47.20	11.80	500.00	450.00	525.00	525.00
Milwaukee.....	35.00	11.80	41.20	12.40	511.00	440.00	565.90	580.00
San Francisco.....	50.00	11.80	52.50	13.50	800.00	640.00	900.00	800.00
San Diego.....	59.00	10.00	59.00	12.00	774.00	652.00	800.00	800.00
San Antonio.....	40.00	11.80	50.00	12.00	630.00	500.00	565.90	600.00
Boston.....	29.50	15.00	29.50	15.00	550.00	495.20	589.00	600.00
Memphis.....	35.40	9.40	47.20	10.00	600.00	442.10	530.60	500.00
St. Louis.....	47.20	10.00	50.00	10.70	525.00	450.00	500.00	599.60
New Orleans.....	25.10	9.40	N/R	14.20	700.00	550.00	550.00	575.00
Phoenix.....	53.10	14.20	50.00	15.00	800.00	530.00	660.20	589.50

¹ Column definitions:

Service	Specialty
a. Initial comprehensive office visit, new patient.....	Internist.
b. Routine followup brief office visit, established patient.....	Do.
c. Initial comprehensive hospital visit.....	Do.
d. Routine followup brief hospital visit.....	Do.
e. Radical mastectomy.....	General surgeon.
f. Cholecystectomy (gallbladder removal).....	Do.
g. Transurethral electroresection of prostate.....	Urologist.
h. Extraction of lens (cataract).....	Ophthalmologist

Senator DOLE. As I understand it, section 20 allows rural hospitals to be reimbursed under medicare for extended care service. Do you support that proposal?

Dr. BEDDINGFIELD. Yes, we would.

Senator DOLE. Do you see any problems at all with that? There was some question raised by the extended care people that it is talking about oranges and apples, a part that might be set aside for extended care is not suited for extended care. You might want to put it back in the patient-type function. You have to convert it.

Dr. BEDDINGFIELD. We would certainly support this principle. There may be details that need to be worked out.

To us it makes uncommonly good sense. For example, Senator Dole, it is not unusual to have a patient in the hospital—perhaps, let's say, a stroke; that is a good example—the patient stabilizes, gets over the acute, critical phase of the stroke and he could be moved to an extended care facility. There is no vacant extended care facility bed in the area. He lives alone; you cannot send him home.

This does result, and has resulted, in many, many instances, of prolonging unnecessary hospitalization. From a humanitarian point of view, you simply cannot put the patient out on the street.

I do not think it would require a great change, if any, in the physical facilities of the small hospital. You keep them in the same room, same bed. You simply categorize his appropriate level of care, and reimburse accordingly.

I submit that makes very good sense. If that patient does have a stroke and you do place him in extended care facilities, and after a month he becomes acutely ill again, then you have a patient who is again inappropriately in a nursing home when he should be in the hospital. If you had him under the same roof, you could provide him with an intensity of the level of care that is appropriate, and reimburse it accordingly. I think this is a very progressive thing.

Senator DOLE. I think it is, too, especially in rural areas where we do not have two facilities we can utilize. We have one that we may be able to use. We do not have the second one. This seems to me to make a great deal of sense. Maybe it needs modification.

Finally, there is provision in the law that would place some restriction on the release of confidential financial information. Of course, this was based on the very gross error made recently where many physicians were held up to some scorn and ridicule, and probably abuse, in their local communities, at least editorially, because of misinformation. That provision is in the bill. The important thing is the accuracy.

I do not suppose physicians would object to the information if it were accurate.

Secretary Califano promised the chairman that from now on there would be a better review of that information, and I think on that basis there may have been some indication that the provision would be deleted or softened. I do not know how you insure accuracy in the Federal Government, unless you abolish it.

Do you have any comments? You are not opposed to the information's being released?

Dr. HOLDEN. Senator, I think the thing about this type of information is that it should be, first of all, accurate, and the circumstances under which the income is developed should be part of the information that is released.

It is inappropriate to give the information Dr. X in such and such a city that received \$200,000 from medicare payments without providing the fact that he was part of a group, that he may have been one of 12 people. It is quite customary in a group to have one individual sign all the forms as the chief honcho or chief of the group. He signs all of the forms and the returns are made in his name.

Accuracy as to the actual dollar amounts, as well as the proper statement as to the circumstances as to which the income is derived, should be made.

Senator DOLE. I share that view. There is a tendency for those writing headlines—it does not make as good a headline if you name 12 physicians instead of one. I think that would be helpful, and it certainly should be included.

It is a fact, if you are going to write the story, you should deal with facts. That is not necessarily the case.

Dr. HOLDEN. We do not have any objection to the actual facts. As Dr. Beddingfield said, we are the whipping boys. We get it one way or the other.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, gentlemen. I might say Senator Dole did say that Secretary Califano did pledge to this subcommittee that he would make every effort to insure accuracy in the future. If he does that, I have no problem with this being made public.

Thank you very much.

Mr. PETERSON. Mr. Chairman, Dr. Beddingfield made reference earlier to the portion of your bill with respect to hospital cost containment, indicating that was a better approach than the administration's approach in its bill, and we would like to submit for the record our testimony that was given on the administration's proposal.

Senator TALMADGE. Without objection, it will be inserted.

Senator Dole?

Senator DOLE. It may be helpful if you would give us suggestions on how we can insure accuracy on the release of information.

Dr. HOLDEN. May we submit that in writing?

Senator DOLE. You had a good suggestion where you had a dozen people, as the chairman said, one signs for it and the headline says he is the recipient, which is not the case.

[The following was subsequently received for the record:]

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., July 6, 1977.

HON. ROBERT DOLE,
Subcommittee on Health, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR DOLE: During the American Medical Association's testimony on S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act, on June 9, 1977, we strongly supported the provision that would prohibit the publication of lists of physicians and the amounts they receive from Medicare and Medicaid. At that time you asked our witnesses what could be done to insure the accuracy of such lists. I am taking this opportunity to provide you this information.

As you know, the publication of this material is of great concern to the AMA and members of the profession because of the inaccuracies the lists have con-

tained in the past. The publication of mere figures, without any amplifying information, has resulted in physicians being needlessly embarrassed, and unfairly harassed and subject to rumor and innuendo.

We believe that accuracy of any lists could best be maintained by allowing each physician on the list to examine and verify the figures prior to publication. In addition, the physician should be able to supply pertinent data which he feels would give more meaning to any reported figure. For example, he might wish to note that his is a group practice and all billing is done in his name. This is a common practice that is not revealed by merely publishing a dollar amount, but obviously would have a strong bearing on the significance of the figure.

Physicians might also wish to list the number of ancillary staff employed. Very often the physician employs a large staff in order to provide a wider range of patient services.

The number of Medicare-Medicaid patients seen might also be included by way of amplification. A very large urban practice, or one in a retirement community, could well have many patients under these programs, thus readily accounting for increased billings.

These suggestions are by no means exhaustive, but are intended as examples of those items a physician might wish to include by way of amplification of the dollar amount.

However, we reiterate our support for the provision of S. 1470 that would prohibit publication of receipts by physicians from Medicare and Medicaid. We do not believe that the public interest is best served by this publication.

If we may be of further service to you, please contact us.

Sincerely,

JAMES H. SAMMONS, M.D.

Senator TALMADGE. Thank you very much.

[The prepared statement of Drs. Holden and Beddingfield follows:]

STATEMENT OF RAYMOND T. HOLDEN, M.D. AND EDGAR T. BEDDINGFIELD, JR., M.D.,
AMERICAN MEDICAL ASSOCIATION

HOSPITAL REIMBURSEMENT CHANGES

Reasonable cost determinations for hospitals under Medicare (sec. 2)

For purposes of reasonable cost reimbursement, a uniform system of accounting and a system of uniform functional cost reporting for determining operational and capital costs would be established for hospitals. All hospitals would be classified according to size, type and other criteria, and an "average per diem routine operating cost" would be determined for hospitals in each category. In general, a payment to a hospital for routine operating cost would be determined for hospitals under a formula applying an average "per diem payment rate" adjusted for price increases and special circumstances. Special allowances would be made in shortage areas for hospitals which were certified as being necessary by an appropriate planning agency and which were underutilized.

A hospital with actual costs equal to or greater than adjusted rates, would receive the greater of its actual cost (not exceeding 120 percent of adjusted rates) or the amount it would have received if classified in the next nearest bed-size category (but not exceeding actual cost).

A hospital with actual costs less than adjusted rates would receive actual cost plus the smaller of 5 percent of adjusted rates or 50 percent of the amount by which the adjusted rate exceeds the actual cost.

Comparable reimbursement methods would be developed by the Secretary for all other hospital costs, and for reimbursing other health care institutions reimbursed on a reasonable cost basis.

The new cost determination procedures for hospitals would be informational and advisory until July 1, 1979 and would be effective with the fiscal year 1981. Medicaid reimbursement to hospitals could not exceed the amount determined under the new Medicare formula.

These provisions would not apply to hospitals in a State having a program for State rate-making provided it applies to all hospitals in the State, it applies to all revenue sources, all hospitals conform to the accounting and uniform reporting (as above) and aggregate payments are less than they would be under the federal program.

In addition, institutions would agree under Medicare and Medicaid not to increase amounts due from any individual, organization, or agency in order to offset reductions made under these cost determinations.

We are deeply concerned that the quality of patient care could be sacrificed in some situations by this proposed methodology for the determination of reimbursable hospital costs if this methodology were to be applied across the country. A hospital would be paid not on the basis of its actual costs, but on the relationship of its actual costs to average costs for its hospital classification. These determinations for hospital reimbursement would not operate as a standard for the reasonableness of each hospital's costs; they would constitute restrictions on the reimbursement of costs to a hospital.

Reimbursement ceilings for individual hospitals, as set by Section 2, are not based on an actual assessment of what it costs to provide hospital services. The leeway permitted hospitals whose actual costs are above average, the special allowance for those which are below average, and any special consideration for hospitals which are understaffed or which have special cost problems or serve needy areas are commendable. But clearly, as an end result, the payment of actual and necessary costs of providing hospital care is no longer the controlling factor; instead a system is created for setting arbitrary statistical limits on hospital reimbursement.

Furthermore, the restrictions on a hospital's ability to pass on unreimbursed costs mean that hospitals will be forced to absorb the differential between actual costs and reimbursable costs. This can only result in an eventual diminution of services offered or a decline in their quality. Neither result is desirable from any point of view.

The proposal provides no assurance that inefficiency will be corrected. The prescribed methodology simply creates a pressure to reduce costs to a set dollar amount without regard to how such reductions may be attained.

We recommend that section 2 not be adopted as proposed for full implementation. Medicare and Medicaid are represented to provide health care in the mainstream for their beneficiaries. The federal government must meet this commitment. We cannot subscribe to or condone "average" health care services for our elderly and disadvantaged in order to accommodate payment "on the average".

However, we do recognize the need to work out appropriate solutions to problems of health care costs. Therefore, we would suggest that this particular cost containment measure be instituted on an experimental basis with limited geographical application for a sufficient period of time so that its effects might be properly monitored and evaluated before a nationwide system is instituted. We believe that to attempt this system on a national basis, without any data as to its effects, would be unwise. Section 2 should be modified to make this proposal initially a local experimental one.

Inclusion in Reasonable Cost of Hospital Services of Allowance for Retirement or Conversion of Underutilized Facilities (Sec. 3)

Section 3 would authorize increased payments from Medicare, Medicaid and Maternal and Child Health Care funds to cover a "reimbursement detriment" as a result of a qualified conversion or closure of underutilized facilities. This would authorize an increase in payment as recommended by the Hospital Transitional Allowance Board, and finally determined by the Secretary, when such conversion or closure resulted in a reduction in capital-related reimbursement or in costs above those reimbursable under the "reasonable cost" determination formula.

We support the principle of providing assistance to hospitals which would suffer a "reimbursement detriment" as a result of voluntary conversion or closure of facilities which are underutilized and for which adequate alternative sources of care are available in the area. This could encourage a more effective use of hospital facilities. Initiating this support on a limited basis, as provided in the bill (for 50 hospitals), will enable an assessment to be made of this mechanism before more widespread application is attempted.

We do have some reservations concerning the use of Social Security health care funds for a program of assistance for the conversion or closure of facilities. In effect this would be devoting Social Security health care funds for other than direct health services. In our view, funding for the conversion or closure of facilities might more properly be provided from other sources.

Federal Participation in Hospital Capital Expenditures (Sec. 4)

Section 1122 of the Social Security Act would be amended to specify that for purposes of Section 1122 review the State Health Planning and Development Agency is the designated agency. Reimbursement of expenses incurred by planning agencies under section 1122 would be available out of any health care funds under Social Security including the Federal Hospital and the Supplementary Medical Insurance trust funds.

Additional amendments would provide for disallowance for any reimbursable amount allocable to capital expenditures or direct operating costs (to the extent associated with the capital expenditure) if the planning agency had not been notified by the facility of a proposed capital expenditure 60 days prior to the expenditure or if, after a fair hearing, the planning agency had not approved the capital expenditure. Any facility seeking a capital expenditure approval and located in a Standard Metropolitan Statistical Area encompassing more than one jurisdiction would have to obtain unanimous approval of all planning agencies.

We believe that it is inappropriate to reimburse state agencies for planning functions from funds earmarked for patient care services. The expenses should be paid out of appropriations made for that purpose, not from Social Security trust funds.

We also believe that requiring unanimous approval of all planning agencies associated with a multi-state SMSA is unnecessary. Such a requirement builds in additional delays to the approval process. The recommendation of the planning agency in the state where the institution is located should be sufficient.

PRACTITIONER REIMBURSEMENT AMENDMENTS

Agreement by Physicians to Accept Assignment (Sec. 10)

This section would create under Medicare a special class of physicians designated as "participating physicians".

A "participating physician" would be one who agreed with the Secretary to accept all Medicare reimbursement for his services on the basis of an assignment. The amounts recognized as the reasonable charge under the assignment would have to be accepted by the physician as the full charge. In addition, the "participating physician" would obtain from each Medicare recipient a signed statement authorizing the assignment and releasing any medical information needed to review claims.

"Participating physicians" would be permitted to submit claims on a simplified basis, including a multiple-listing basis (rather than on an individual patient basis), and would be allowed an "administrative cost savings allowance" of \$1 for each patient as an inducement to participate.

No "cost savings allowance" would be payable for physicians' services performed in a hospital (whether on an inpatient or outpatient basis) unless the physician ordinarily bills directly and such services were surgical or anesthesiological services or were performed by a physician who personally examined the patient and whose office or regular place of practice was located outside a hospital.

No "cost savings allowance" would be recognized for services consisting solely of laboratory or X-ray services for hospital inpatients or outpatients or performed outside the office of the physician claiming payment.

This proposal is designed to increase the sagging rate of acceptance of assignments by physicians. Certain inducements are offered to achieve this goal. A "participating physician" would receive an "administrative cost savings allowance" for each patient. The provision also implies that the claims of "participating physicians" would be processed faster than those of nonparticipating physicians. It further creates two classes of physicians—participating and nonparticipating. To the Medicare patient, the message will be clear—patronize the "participating" physician rather than the non-participating.

However, the use of inducements, direct or indirect, does not reach the issue of why the assignment is so little used. The fact that inducements are necessary in order to buttress a sagging assignment rate should cause an examination of basic factors involved. Without question the current system, with its insufficient reimbursement rate, is the major deterrent to assignments. The artificial and discriminatory payment mechanism under Medicare has caused a rejection of the assignment method of receiving payment. The 75th percentile formula, applied to outdated and unrealistic data (at times almost two years old) and further curtailed through application of the economic index, has caused

many physicians to be disenchanted with the assignment method. It also should be observed that in seeking to foster acceptance of assignments S. 1470 is dichotomous. In one section it seeks to provide inducements for assignments, while in another it discourages such use through the imposition of more reductions in payment.

Rather than seeking new devices to bolster assignment usage that are based on the perpetuation of artificial and arbitrary payment levels, it is time to examine and make realistic the basic Medicare reimbursement formula and payment mechanisms. If indeed it is the intent of Section 10 to achieve more widespread acceptance of assignments, it would be better accomplished by making the reimbursement level under that system more acceptable and in accord with usual and customary practices. Medicare limitations, as through application of the economic index, are discriminatorily imposed, and should be removed.

As to the multiple list billing mechanism, one assumes there are administrative advantages for Medicare and the physician that underlie this proposal. If so, there is no reason why this payment feature should not be put into effect immediately. The provision for early—or more appropriately, timely—payment is certainly no more than physicians are entitled to and should receive at the present time, without the necessity of statutory mandate. It would be disheartening if convenient administrative aids are now available—but are not being utilized.

Section 10 as now written will not contribute to the continuation of quality care under Medicare and should not be adopted.

Criteria for Determining Reasonable Charges for Physicians' Services (Sec. 11 and 12)

The bill would significantly change determinations of reasonable charges under Medicare. At the present time prevailing charge levels are set in localities so that the prevailing charge level would cover 75 percent of the customary charges made for similar services in that locality. Certain additional limitations are imposed so that the charge level for any fiscal year beginning after June 30, 1973 would not exceed the level determined during the fiscal year that ended on that date, except to the extent that a higher level is justified by economic changes determined to be acceptable by the Secretary on the basis of appropriate economic index data.

Under S. 1470, however, the Secretary would determine state-wide prevailing charge levels for each State. The prevailing charge level of the State would be based on 50 percent of the customary charges made for similar services in the State.

Prevailing charge levels in a locality would remain subject to the economic index but the bill specifies that for an economic index increase for any particular service, "no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level . . . for that service."

This procedure could, in many cases, result in a diminution in future increases in the reimbursable amount which physicians might otherwise receive. It appears that the real effect of the new methodology would be to cause a leveling of reimbursement. This leveling would be accomplished, however, through a reduction (particularly in metropolitan areas) in the amount of increases which otherwise would be due under the economic index and to which physicians currently are entitled. While the reimbursement levels in non-urban areas might for a period of time undergo normal increases which could be higher (as a percentage) than those to be recognized in metropolitan areas under the economic index, this stifling of proper fee recognition for all physicians would be detrimental to maintaining a proper level of care under the program.

Discrimination in the application of the economic index in states with two or more localities would result. Some physicians would receive the full amount allowed by the index, others would not. Further discrimination would result because the index would apply fully to all physicians in states constituting a single locality. The artificial ceiling imposed on Medicare reimbursements could affect participation by physicians and affect the availability of care for Medicare patients. This type of limitation would also further aggravate the shifting of expenses not reimbursed by Medicare and Medicaid to patients under private programs.

In our opinion, reimbursement levels imposed upon physicians are already substandard. This provision would further reduce this standard and thus adversely affect Medicare patients. This provision should not be adopted.

A further provision in sec. 12 also affects the amount a physician may be reimbursed. The charges of a physician or other person related to income or receipts of a hospital or hospital subdivision would not be taken into consideration in determining his customary charge to the extent that such a charge exceeded what a salary (plus certain expenses), as determined by the Secretary, would reasonably have been if the physician or other person had been employed by the hospital.

This provision presupposes that these contractual arrangements automatically result in excessive remuneration and that by "outlawing" certain forms of contract, excessive charges will be avoided. In point of fact, excessive reimbursement is not the result of the form of financial arrangement, but instead results from the intentions of the parties involved. Limiting the freedom of contract will not control or eliminate any problem of excessive reimbursement. What it will do is make it more difficult for certain institutions to provide needed services to Medicare patients.

We further question the appropriateness of the Secretary's power to determine a "reasonable salary." On what basis will this be decided? No guidelines are provided in this bill and, therefore, the discretion given to the Secretary is excessive.

This provision should be deleted from the bill.

We note that one provision in section 11 is intended to permit greater flexibility in the recognition of charges in physician shortage areas.

The intent of this provision is salutary. The current needs of certain areas for medical care are well recognized and a variety of ideas should be tried in order to solve these shortages. We would recommend, however, that the definition of shortage area be consistent with that in other laws. There is no need to create another definition of shortage areas exclusive to Medicare that will overlap areas established under other statutes.

Hospital-Associated Physicians (Sec. 12)

Section 12 would establish a stringent definition of "physicians' services"; would enact statutory definitions of reimbursable anesthesiology and pathology services; and would reduce the Medicare payment for radiology and pathology services if the physician providing them did not accept assignment.

Medicare law now defines "physicians' services" as "professional services performed by physicians". S. 1470 would amend that definition to exclude those services the physician performs as an educator, an executive, or a researcher. The amendment would exclude even patient care services unless "personally performed by or personally directed by a physician" for the benefit of the patient and unless the service is of such a nature that its performance "by a physician is customary and appropriate."

It should be made clear that although this amendment comes under the heading "Hospital-Associated Physicians" the amendment is not so limited, and the placement of this amendment under that heading is misleading. In fact this amends the general definition of "Physicians' Services" in section 1861(q) and consequently the new limitations apply to all "physicians' services" under Medicare. We object strongly to this modification. All activities of physicians customarily recognized as part of the physician's practice should be reimbursable as "physicians' services" under Medicare. A strict application of this language would have dire consequences for proper recognition of, and payment for, all services of physicians under Medicare.

Even if the provision was intended to affect only the inpatient services of "hospital-associated physicians", the modification would still be objectionable.

The writers of regulations, armed with this proposed statutory language, could arbitrarily change the practice of medicine as recognized today to the detriment of both the patient and the profession.

Whatever its intent, a legal definition which states that a physician acts as a physician only when directly treating a patient and when performing services only a physician can perform will ultimately lead to confusion in the Medicare program and further dismemberment of health care.

Furthermore, the physician as educator, researcher, or administrator does not cease to be a physician; indeed, since the earliest days of the medical profession, teaching and research have been recognized as intrinsic parts of the practice of medicine. As medicine has become more organized and technologically sophisticated, administrative tasks have developed which can be performed most effectively only by a practicing physician.

We protest strongly any artificial division of the physician's role.

We further protest, therefore, the attempt to define precisely what are "personally performed" or "personally directed" services in the fields ofesthesiology and pathology. Medicine is a living science, which changes rapidly and dramatically. Laws may take years to change. Even the regulatory process, as this Congress is well aware, can be dilatory and inflexible. The language of these sections goes further in limiting medical practice than the laws under which these physicians are licensed to practice. Its restrictions on anesthesiology and pathology are not only unwise legislation in themselves, but tend to undermine the very mechanism established by Congress in 1972 designed to improve care under Medicare, Medicaid, and Maternal and Child Health programs. Congress then established PSRO's to determine whether patients under the three programs receive care which meets appropriate professional standards of quality. Decisions as to what constitutes proper physician services were delegated to local professionals who are better equipped to make such determinations than government employees.

This bill would superimpose on PSRO deliberations specified artificial standards as to how many patients a physician could personally treat, or personally direct treatment for, and still have the treatment considered a "physician's service". It would say which services of pathologists are "physician's services" and which are not. PSRO's were properly given the charge to determine the propriety of medical services and if they met professional standards. Congress should not undermine this function.

We suggest that this Committee consider very carefully the limitations this law would set on care recognized as properly provided by anesthesiologists. For purposes of the program, an anesthesiologist could "personally perform" physicians' services for only two patients at a time, and could only "personally direct" care for four patients at a time. The "reasonable charge" for "personally directed" care will be half that for "personally performed" care.

By this standard, an anesthesiologist will receive the same payment for two patients for whom he provides all the listed services as for four patients for whom he provides all but one of the listed services, but for whose care he remains legally liable. This change could well result in a reduction in the anesthesiology services available to Medicare, Medicaid, and Title V patients.

The Congress should not set in inflexible statutes the elements that constitute acceptable performance of practice by anesthesiologists or pathologists or any other physician.

Finally, in Section 12, the bill would enact an approach which is intended to "encourage" physician acceptance of assignments—but it does so by penalizing the patients if they do not. Under present law, pathology and radiology services to hospital inpatients are paid under Part B at 100 percent of the "reasonable charge," whether the physician has accepted assignment or not. S. 1470 would change the amount of Medicare payment to the usual 80 percent of the "reasonable charge" if the physician does not accept assignment, and permit crediting of the patient's 20 percent of the "reasonable charge" towards the annual Part B deductible. We point out that the Medicare "reasonable charge" for pathology and radiology services remains the same, whether or not the physician accepts assignment.

The Association questioned whether the coinsurance factor should be eliminated for specific segments of medical care during the discussions prior to passage of Public Law 90-248. We question even more strongly the establishment of different rates of payments by Medicare for similar services when provided on assignment or when billed to the patient. We believe that this approach violates basic principles of equity to the Medicare beneficiaries, who pay the same out-of-pocket premium but would receive different degrees of coverage as a result of factors over which they have little or no control.

These proposed definitions of "physicians' services" are described as an effort to control health care costs by limiting reimbursable services under Medicare. In actuality, it is an effort by the government to evade its responsibilities to Medicare beneficiaries who depend on this program for their health care. Changing the definitions does not change the true costs of services, but merely shifts the burden of financial responsibility from the government to the patient who can ill afford such a shift.

For the government to renege on its promises to the elderly can only result in a further diminution of confidence in our federal system.

The changes, ostensibly aimed at the physician, will in the end cause the most harm to the patient.

We strongly urge that section 12 not be adopted.

Payment for Certain Antigens Under Part B of Medicare (Sec. 13)

There would be added to the definition of "medical and other health services" provisions to include antigens (as limited in quantity by the Secretary) prepared by an allergist for a particular patient. Included also would be antigens prepared and forwarded to another qualified person for administration to the patient by or under the supervision of another physician.

We believe that this provision is a beneficial one. It would answer questions concerning payment that have been raised with respect to antigens prepared by allergists. Providing payment for these services will be beneficial for many Medicare beneficiaries. We recommend support for section 13.

Payment Under Medicare of Certain Physicians' Fees on Account of Services Furnished to a Deceased Individual (Sec. 14)

Medicare payment to a physician for services rendered to a person who died prior to payment to, or acceptance of an assignment by, a physician presently may occur only if the physician agrees later to accept payment under the terms of an assignment.

This new provision would enable a spouse or other legal representative of the deceased person to authorize payment to the physician under Part B without regard to the acceptance of an assignment by the physician.

We believe this provision would aid the orderly administration of the Medicare program and be of benefit to the heirs and representatives of deceased Medicare beneficiaries in estate administration. We are in support of this provision.

Use of approved relative value schedule (see 15)

The Secretary of HEW would establish a system of procedural terminology under Medicare, Medicaid and Maternal and Child Health as developed by the Health Care Financing Administration (HCFA) with the advice of professional groups and other interested parties. Upon development of the procedural terminology, it would be published in the Federal Register for six months' comment and for recommendations as to relative values for procedures and services designated.

Any association of health practitioners in "good faith" preparing or submitting a relative value schedule would not be barred from doing so because of any consent decree waiving its rights to recommend fees provided such schedule is not disclosed to anyone other than those preparing the schedule or their counsel, until made public by the Secretary. HCFA would recommend that the Secretary adopt a specific terminology system and its relative values for use under Part B of Medicare, but only after analyzing and evaluating the system and determining that its use would enhance the administration of the federal health care financing programs.

After adoption of a system by the Secretary, any organization or individual could use it for purposes other than for this bill. The Secretary could adopt a terminology system without adopting a relative value system and could modify any system adopted.

The use of relative value schedules (RVS) can, if properly designed and implemented, be a useful administrative tool in any system of health care reimbursement. However, a RVS must not be so rigid as to preclude adjustments in fees based on regional cost-of-living differences, overhead or other factors that affect physicians' fees in a particular locality.

Above all, a RVS should not be used to "fix" fees either by practitioners or the government on a regional or national level.

We are concerned about this particular proposal because of the discretion available to the Secretary, and residing solely in the Secretary, in establishing the relative values. In determining any RVS, he is not required to adopt the recommendations of the Health Care Financing Administration or of any professional association and is also free to modify any RVS at any time. Such overbroad authority is not conducive to effective use of the RVS in federal reimbursement programs.

Nothing prevents the Secretary from using the RVS to create a federal fee schedule. We would oppose such a move.

Likewise, there is nothing in this provision that prevents the Secretary from using the RVS as a lever to lower the already inadequate reimbursement levels under federal health care payment programs. Such a move would only make it more difficult for the beneficiaries of titles V, XVIII and XIX to obtain quality

care. There should be proper recognition of the wide acceptance in the profession of the Current Procedural Terminology (CPT).

We urge the committee to incorporate in section 15 appropriate safeguards for the development and use of the RVS to insure its proper implementation, and to keep it from being used as a fee reduction system.

We again remind the committee that a lowering of reimbursement levels represents cost savings only to the government. The actual cost of the service does not change and the difference between actual cost and reimbursed cost usually is made up by higher prices on other services to nongovernment patients or an increased cost to the Medicare beneficiary.

It is unrealistic to expect physicians to donate services on a massive scale. A system of inadequate reimbursement can only lead to inferior health services.

We note that this provision would permit other uses of the approved RVS. This is an effort to overcome certain legal obstacles that now prevent the use of an RVS. However, because of the complexity of the legal situation surrounding the use of the RVS, we are not sure that the language of section 15(e) is sufficient to overcome the present restrictions on its use. We urge that the language be re-evaluated. We oppose adoption in its present form. Legislation should recognize and provide for use of terminology and relative value schedules as developed by the profession.

LONG-TERM CARE REFORMS

Hospital providers of long-term care services (sec. 20)

Title XVIII would be amended to allow rural hospitals of less than 50 beds having average daily occupancy of less than 60% to enter into agreements with the Secretary to provide extended care services using inpatient hospital facilities. These hospitals would have to meet other conditions prescribed by the Secretary, obtain a certificate of need for provision of long term care services from the health planning agency, and would be reimbursed at the Medicaid level of skilled nursing facilities in the State. A hospital having such an agreement would be considered as meeting most of the otherwise applicable Medicare requirements for providing extended care service.

Medicaid would also be amended to provide reimbursement for skilled nursing services and intermediate care services of a hospital having such an agreement.

This provision is designed to allow certain rural hospitals flexibility in their use of hospital beds. Under present law, long term care services offered by a hospital must be located in a separate unit of the hospital. Such a requirement often works a hardship on rural hospitals with limited facilities since they cannot reasonably comply with the separate location requirement.

This amendment recognizes this handicap of many small, rural hospitals and allows them to use available bedspace for multiple purposes for which they will be reimbursed under Medicare and Medicaid.

This is a sensible response to this situation and we support the provision.

Medicaid certification and approval of skilled nursing facilities (sec. 22)

This section provides that the Secretary would enter into an agreement with any State able and willing under which the services of the State health agency, or other appropriate State or local agencies, would be utilized by the Secretary for the purpose of determining whether an institution in the State was qualified as a skilled nursing facility for purposes of the Medicaid program. Notwithstanding certification by the State agency, however, the Secretary is empowered to accept or reject such certification and would make the final determination for each institution.

In our opinion this section of the bill would create confusion and uncertainty in the program and constitutes an unnecessary and unwarranted involvement of the Federal government. The present procedure which recognizes certification by state agency as determinant of eligibility for Federal Medicaid payment to the states should be retained. Section 22 should not be adopted.

Patient absences from facility (sec. 23)

We support Section 23 of the bill on "Visits Away From Institution by Patients of Skilled Nursing or Intermediate Care Facilities".

This section would provide that under Medicaid an inpatient of a skilled nursing or intermediate care facility could make visits outside the institution

and that such visits would not be regarded as conclusively indicating that such individual was not in need of the facilities services.

This provision provides desirable flexibility in the course of treatment of skilled nursing and intermediate care facility patients. Such flexibility could produce positive results in patient care.

ADMINISTRATIVE REFORMS

Establishment of the Health Care Financing Administration (sec. 30)

There would be established within HEW a separate unit known as the Health Care Financing Administration (HCFA) under the direction of an Assistant Secretary of Health Care Financing appointed by the President. This Assistant Secretary would have policy and administrative responsibility for Medicare, Medicaid, PSRO, and the renal disease program under the Social Security Act.

In our testimony in the last Congress, we voiced our concern over what the long range effects of the creation of HCFA may be for health care in this country.

While we recognize the need to keep a rein on health care costs, we urge that any measure be closely scrutinized for its ultimate effects on the patient. Nothing is gained by depriving patients of quality treatment because of shortsighted "economy" measures. It may be well not to crystallize the new structure with statutory formality, allowing time to test the desirability of continuing cost and quality functions in one unit relating to health. In our view matters relating to quality would more appropriately be under a health oriented unit rather than one geared to financing.

This change has largely been accomplished by administrative action. Our concern is that matters of quality of care may become submerged in, and of only ancillary concern to, costs of health care. Increasingly now we see matters of cost taking priority consideration.

State medicaid administration (sec. 31)

This amendment would add new criteria to State Plan requirements under Medicaid. Medicaid eligibility determinations would have to be made for all applicants receiving payments on the basis of disability within at least 60 days, and for applicants receiving assistance on the basis of AFDC, age or blindness, within 45 days. Redetermination of eligibility for these two categories would have to be made within 30 days after the State received information which would change a recipient's eligibility and in any event at least every 6 months for AFDC recipients and at least annually for recipients of aged or blind assistance.

In addition, other proposals are designed to improve the State's administration of its Medicaid program.

Penalties could be assessed for uncorrected deficiencies in a State's performance in the form of reduction or termination of the federal contribution to Medicaid administrative expenses. An increased federal contribution would be made to States exceeding performance requirements.

States would also be required to improve their schedule of reimbursement of Medicaid claims.

The administration of Medicaid at the State level has been too uneven in the past. The poor performance record of many states is discouraging to providers and beneficiaries alike. We support these efforts to improve the administration of Medicaid, especially those provisions calling for more rapid determinations of eligibility and improved payment of claims.

We urge caution, however, in the selection and administration of penalties. The use of a penalty can be appropriate, but must not be handled in such a way as to penalize the beneficiary for actions taken by the State over which the patient has no control.

Health Insurance Benefits Advisory Council (sec. 33)

Section 33 of S. 1470 mandates the dissolution of the Health Insurance Benefits Advisory Council originally enacted under Public Law 89-97. When the 89th Congress created (as part of the original Medicare and Medicaid enactment) HIBAC, it was not its intent to establish this as an "ad hoc" or temporary advisory body. Congress envisioned an active and constructive advisory role for HIBAC and expected that the Secretary would take full advantage of it.

We recognize that HIBAC has not been as active or contributory as it might have been. However, the fault lies not with the body itself, but rather with its use—or disuse—and to the staffing—or lack of staffing—it has received. In our view the Congress, rather than abolishing HIBAC, should strengthen it by requiring that it receive the support necessary to permit it to function as an effective advisory body to the Secretary.

We therefore urge that Section 33 be rewritten to strengthen HIBAC and to make it truly effective.

Regulations (sec. 32)

S. 1470 provides that a proposed rule or regulation issued under the Social Security Act would become effective within 60 days following the publication in the Federal Register of the notice of such rule or regulation if the notice indicated that prompt promulgation was urgent. Any other regulation would be promulgated pursuant to other applicable law.

We do not believe that the processes of the Administrative Procedure Act should be bypassed. It is difficult enough for the public to have a sufficient opportunity to study and comment upon proposed regulations, without amendments that shortcut the system. If a regulation must be finally promulgated before a certain statutory deadline, then HEW should offer the proposal well enough in advance of the final date to allow ample opportunity for public discussion and comment. The government should not be given a statutory excuse for its own procrastination.

The promulgation of regulations implementing Federal health programs, particularly Medicare and Medicaid, is one of the more vexing problems confronting the medical profession.

In testimony the AMA has previously offered to Congress during hearings on proposed changes to the Administrative Procedure Act, we have urged a major restructuring of the Act to afford opportunities enabling the public to respond meaningfully to proposed regulations, and to require that Federal agencies accurately reflect the intent of the law and be more responsive to the public's comments. In response to repeated agency abuses of the APA, the AMA has developed its own legislative proposal.

Section 32 also proposes a second modification in present law relating to the promulgation of regulations. It directs that regulations necessary to implement the provisions of the bill, or any provision of law enacted or modified by the bill, be promulgated so as to become effective within one year after enactment of S. 1470.

While we are certainly in favor of prompt promulgation of rules, the broad mandate of this section cannot be supported inasmuch as it would surely result in the publication of hastily conceived and inadequately developed regulations which would not be in the best interest of a proposer and orderly development of programs established under the law. The concept of requiring prompt promulgation of regulations is salutary; however, the statutory mandate does not in our opinion provide an appropriate solution to a situation widely recognized as being in dire need of remedy.

We would urge the deletion of this section from S. 1470. We further suggest that problems with administrative procedures be resolved through comprehensive reform of the APA.

MISCELLANEOUS CHANGES

Ambulance service (sec. 41)

We recommend a slight modification of Section 41 relating to "Ambulance Service", and offer our support for this section as modified.

Under this section of the bill, Medicare would be extended to provide for ambulance service to the nearest hospital which was both adequately equipped and had medical personnel qualified to deal with, and available for the treatment of, the individual's illness, injury or condition.

Improved ambulance coverage for Medicare patients is highly desirable. However, this provision is not clear as to who will make the determination of which hospital is "nearest" the individual. An amendment to this section should be made to provide that within reasonable limits, this determination should be made by the patient. This would assure that the patient could enter the hospital at which his physician has medical staff privileges, but which may not in fact be the hospital "nearest" the patient. We would recommend that Section 41 be changed to provide for reasonable determination by the patient.

Disclosure of aggregate payments to physicians (sec. 44)

The Social Security Act would be amended to prohibit the Secretary from making available (and to prohibit any requirement of a State Medicaid agency to make public) information pertaining to amounts paid physicians for or on behalf of beneficiaries of Medicare or Medicaid except to the extent necessary to carry out the purpose of the programs or as required by other federal law.

The AMA is pleased to see an effort finally being made to terminate the annual publication of lists of providers receiving funds above a certain level from Medicare and Medicaid. The disclosure of this information has served no useful public function, but merely has been a means of attacking the profession through innuendo. The revelations of massive error in the most recent list issued by HEW underscore the need to put an end to this practice.

We strongly support the provisions of section 44.

CONCLUSION

We have discussed many of the provisions of S. 1470. As we have indicated, this bill would have serious and far-reaching ramifications with respect to services furnished under the Medicare, Medicaid, and Maternal and Child Health Programs. While the thrust of the bill is cost containment for these programs, the full effects would be broader, affecting the quality and availability of care not only to program beneficiaries, but also to other patients.

In view of the continuing inflationary pressures in our economy, we are indeed sympathetic with the intent of this legislation to seek limitations upon rising health care costs. It must be recognized, however, that arbitrary curtailments of increases in costs will have natural consequences with respect to maintaining quality and availability of care. Each element cannot be treated separately without expectation of impact on the others. Any changes in reimbursement levels must be carefully evaluated in terms of their ultimate effects on patient care.

In our discussion we have indicated those provisions which we believe are not in the interest of program beneficiaries. We have also indicated our support for other provisions. Taken as a whole, however, the bill should not be enacted as it is not in the best interests of Medicare-Medicaid patients.

As the Subcommittee continues its deliberation on this bill, we urge that our comments and suggestions be carefully considered. The American Medical Association is ready to work with the Subcommittee and its staff in developing appropriate modifications to the Medicare and Medicaid programs.

Senator TALMADGE. The next witness is Mr. Neil Hollander, vice president for health care services, Blue Cross Association.

Mr. Hollander, you may insert your statement in full in the record and summarize for 10 minutes, if you will.

STATEMENT OF NEIL HOLLANDER, VICE PRESIDENT FOR HEALTH CARE SERVICES, THE BLUE CROSS ASSOCIATION

Mr. Hollander. Thank you, Mr. Chairman and Senator Dole.

I am appearing here today on behalf of the Blue Cross Association and our 70-member Blue Cross plans. The association is a prime contractor to the Department of Health, Education, and Welfare and the plan subcontractors play an important role in the administration of medicare nationwide.

Many of our plans administer medicaid and we underwrite private health care protection for more than 80 million people.

Although we are most commonly associated with inpatient hospital care, our plans have contracts with 6,700 hospitals. We cover many other services, including diagnostic laboratory and X-ray, dental, prescription drugs, vision, nursing homes, preventive care, and outpatient psychiatric services.

Last year we paid \$13 billion in benefits for our subscribers, including \$9 million for inpatient claims and \$20 million for ambulatory care.

To save the committee's time, I would like to give a brief summary of our views on S. 1470. More detail is contained in our full statement.

I shall begin first with some overall observations. Our association strongly believes there is an immediate need for enactment of a program to contain costs in the health care field. We favor a program to contain costs with a program to limit hospital inpatient revenues on the basis of class of purchaser, along with positive incentives for the hospitals, and a national moratorium on capital expenditures.

The problem that we are talking about is a massive one. Right now no one has been able to design hospital incentive payments systems or other cost containment tools to achieve lasting and effective results. Because we believe an early effort to contain costs deserves attention, our comments today reflect that concern.

Senator Talmadge, as you pointed out, when introducing S. 1470, the bill is not designed to contain costs immediately. We would like to encourage your consideration of changes that would have an earlier effect.

Section 2, "Criteria for Determining Reasonable Costs, All Hospital Services," contains many of the ideas and concepts that might be considered in designing a revenue limitation program for the short term.

These are, notably, hospital grouping and incentive payments. For longer term programs, these concepts may also prove appropriate.

We would like to see in the bill provisions for flexibility designed exception processes that will give hospitals greater opportunity to contain costs. Since not enough kinds of prospective or other incentive payment approaches have been tried to determine which approach will be best, we do not think that any one approach should be settled upon at this time.

We are concerned that, as drafted, section 2 will not have nearly the early impact needed and will not affect enough of the hospital cost structure. Section 2 would not become effective until 1981. It would apply only to hospital inpatient routine costs; only to medicare and medicaid patients; and only to participating hospitals, not otherwise determined to be in underserved areas or to be underutilized.

About two-thirds of total hospital costs are excluded because section 2 does not cover ancillary costs, education, and teaching costs, malpractice insurance premiums, energy costs, and capital and related capital costs. Including only medicare and medicaid excludes nearly half of the hospital volume. The net effect of the two provisions restricts the impact of section 2 to about one-fifth of total hospital industry costs.

The result of these provisions is that the impact is limited and the opportunity to shift costs from those covered to those not covered is substantially increased. Enforcement of the provision prohibiting such shifts in cost may be quite difficult to manage.

The grouping hospitals into three major categories and into subgroups based on size may not be the best approach to achieve the desired results of identifying high cost, inefficient hospitals.

Unfortunately, there is no known way to classify hospitals by their efficiency, although various systems are being studied.

The incentive system in the bill impacts primarily hospitals operating at between 90 to 100 percent of average costs, although incentives are provided for those below 90 percent.

The bill's penalties apply to those hospitals above 120 percent of the average. We would prefer to see an incentive penalty system that operates across the full range of costs instead of being limited primarily to two zones of financial performance.

In any program such as that provided by section 2, we support a provision for uniform functional cost reporting, but without the requirement for uniform accounting. Uniform accounting could add to operational inefficiency.

We support the transitional allowance provision of the bill and think it is potentially an innovative and important step in developing longterm cost containment measures. We believe that the Secretary should be given latitude to accelerate the program after thorough evaluation. However, there are some issues that should be clarified.

In the case of conversions, where the aggregate reimbursement is reduced, would the facility continue to receive any portion of the amount reduced? Also, it is not clear whether such amounts include operating costs or just capital costs such as interest and depreciation. In the case of closure, that facility apparently receives only an allowance per day. We recommend that all types of costs associated with closure be included.

In section 4, we strongly support the concept of capital expenditure limitations. We think that section 4 addresses important aspects of this issue by further linking medicare and medicaid reimbursement to Public Law 93-641, the Health Planning Act, and extending section 1122 penalties to include direct operating costs associated with capital expenditures.

However, given the magnitude of the health economic problems facing our Nation, we believe that there is a need for a national moratorium on new capital expenditures. We urge that such a moratorium be built into section 4 until decisions are reached on fundamental recurrent reforms in Public Law 93-641, such as the capital limitations now being proposed in other Federal legislation.

In our full statement to the subcommittee we support the concept contained in section 20, "Hospital Providers of Long-term Care," of using hospital beds for long-term care and encouraging extending provisions to hospitals with 100 beds or less. This, we feel, represents the type of positive approach necessary to resolve problems of excess operating capacity.

We agree with the provisions of section 12, "Hospital Associated Physicians," that would limit physician billing patients to where they had rendered the service directly, but we suggest as an alternative method that medicare program payments to all hospital-associated physicians be made to the provider on a combined billing basis where the physician does not have a private patient relationship.

In our full statement, we also raise other technical questions about the bill and comments on sections that I have not taken time to include here.

What I hope to do in this oral presentation is to give you our basic thinking about the bill and about its relationship to the problem of cost containment, hospital reimbursement and capital expenditure limitations. I hope that my comments have been of some help to you and I believe that the full statement will make the position of the Blue Cross organization much more clear.

If you have any questions, I will be glad to try to answer them now. If you need additional information that is not in our statement or which I do not have with me, we will see that that is given to your staff as quickly as possible.

We would also be very happy to consult with them on any parts of the bill. Thank you very much.

Senator TALMADGE. Mr. Hollander, I appreciate your detailed comments. You pointed out that that Walter J. McInery believes that any program of cost containment should consist of two parts, first, hospital revenue control and second, hospital capital controls.

I appreciate your series of constructive suggestions with respect to capital control. With respect to hospital costs or revenue controls, I note that you said that it is easier to see flaws than to develop and recommend alternatives, but I must say that I am somewhat surprised that as the largest third-party payor with the longest history in this area, you are unable to bring us anything but criticisms.

Do you not have a responsibility to your own subscribers to develop constructive costs or revenue control procedures rather than merely criticizing those proposed by others?

Mr. HOLLANDER. The basic answer to your question, Senator, is yes. We do have such a responsibility. In fact, many Blue Cross plans are involved in prospective or other reimbursement experiments around the country that are addressing the reimbursement problem in health care expenditures.

We also have been significantly involved with the development of health maintenance organizations directed toward cost containment and have supported health planning, utilization review programs and other kinds of activities throughout the country that are directed at the issue of cost.

It is now a condition of the membership for a plan in the Blue Cross Association to have a cost containment program.

To speak specifically to the issue of reimbursement, a couple of examples of programs that are in place now that involve Blue Cross plans. One is the maxicap approach that is being tried in Rhode Island and upper New York State. Its objective is to allow a community to receive a total amount of health dollars for all hospitals and then, the hospitals allocate them in the most efficient manner.

I take your suggestion as a critical one, that we do have an obligation to suggest other kinds of things. I personally have several of the best people in reimbursement in Blue Cross throughout the country sitting down and attempting to develop additional incentive kinds of schemes to propose to the Congress. We would be happy to submit them.

Senator TALMADGE. We would be delighted to have those recommendations submitted to the staff for our consideration. I am interested in

your alternative suggestion dealing with hospital based physicians, namely that we require medicare payments to these physicians to be made to the provider and then merely put some limits on the overall extent of the payments rather than getting into the details of how the payments were made.

The Federation of American Hospitals proposed a similar solution saying that we should try a 75-percent test of aggregate payments for these physicians. Do you have any data to indicate the size of the payments to physicians which would result if such a simple test would be applied?

Mr. HOLLANDER. I do not have the answer offhand. I would be happy to submit it for the record.

Senator TALMADGE. Would you find that and try to submit that data for the record?

[The following was subsequently supplied for the record:]

The Blue Cross Association, often reviewing the available data found them inadequate to permit an accurate response to Senator Talmadge's question regarding payments to hospital-based physicians. The type of study needed to produce a reliable answer could not be completed prior to the closing of the hearing record.

Senator TALMADGE. Senator Dole?

Senator DOLE. I want to reemphasize the first point made by the chairman. It would be helpful to know just what you are doing in the cost containment area. I am certain you have ongoing programs. As far as responsibility, it is not enough for government to address itself to cost containment.

I would appreciate personally receiving a copy of whatever you submit to the committee so that we can take a look at it.

Mr. HOLLANDER. I would be very happy to do that, Senator.

Our belief is that the responsibility for health care costs is a shared responsibility, that is, we in government, labor and management equally must participate in doing something about health care costs. It is not a simple problem. We do not have all of the answers. nor does government. But we think, working together, we may be able to be more effective in doing what we need to do to solve this problem.

Senator DOLE. That would include whether you submit to who finally makes the decision on benefits and matters of that kind?

Mr. HOLLANDER. Yes, sir.

Senator DOLE. I notice your recommendation that we not allow a greater return on equity for proprietary hospitals on the grounds that there is no reason to provide incentive for capital in this industry. In fact you said we should move in the other direction.

How do your Blue Cross plans deal with this issue, and do you allow return on equity?

Mr. HOLLANDER. Yes.

Blue Cross plans have contracts with hospitals, including proprietary hospitals, that pay them for the costs associated with serving Blue Cross patients. In the case of a proprietary hospital, many of these contracts would include a return on equity. Our argument, Senator, was not that proprietary hospitals should not receive adequate return on their investment.

Indeed, our argument was, that we thought there was some ambiguity about that provision in the bill. It might be interpreted to mean

that after a period of time that it should not include any return on equity. We believe that proprietary hospitals should have a return on equity. However, we do not think that there is a need to attract additional capital into the health care sector at this time.

Indeed, here are probably more hospital beds than we need. Therefore, we do not see any reason to encourage additional capital.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, Mr. Hollander.

[The prepared statement of Mr. Hollander follows:]

STATEMENT OF NEIL HOLLANDER, VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. Chairman, and Members of the Committee, I am Neil Hollander, Vice President of the Blue Cross Association, the national coordinating agency of the 70-member Blue Cross Plans in the United States and Puerto Rico.

I thank you for the opportunity to share with you our thoughts on administrative and reimbursement reform in the Medicare and Medicaid programs, particularly from the standpoint of health care costs, the focus of many of the provisions in S. 1470.

In government programs, the Blue Cross Association is a prime contractor to the Department of Health, Education and Welfare for the Medicare program nationwide. Individual Blue Cross Plans are subcontractors to the association for this program. Many of our Plans also administer the Medicaid program in their territories.

For privately underwritten business, the Blue Cross organization serves more than 80 million Americans who are significantly affected by the rising cost of health care. In nearly all instances, we provide "service benefits," that is, full or nearly full payment for covered services, in contrast to "indemnity" or fixed cash benefits paid by many commercial insurance policies.

In 1976, we paid \$13 billion in benefits for our subscribers, covering nine million claims for inpatient hospital care and twice that number—twenty million—for outpatient and other ambulatory care.

Our Plans have contracts with 6,700 hospitals, covering both inpatient and outpatient services. In addition, 30 of the Plans are involved with 57 health maintenance organizations, mostly the prepaid group practice type, to help give our subscribers a choice of the kind of care they will receive.

We have been most closely identified with hospital coverage. But now, to a significant degree, we also cover diagnostic laboratory and X-ray services, dental care, home health care, prescription drugs, vision care, nursing home care, ambulance service, preventive care and outpatient psychiatric services.

Because of consumer demand for broader benefits, our payments would have gone up over the years even if the cost of care had remained constant. However, costs have increased significantly.

GENERAL OBSERVATIONS OF S. 1470

Because many sections of S. 1470 have been carried forward from last year's bill, S. 3205, I will not comment specifically on most of the provisions of S. 1470. I refer you to our testimony last year which supported, in whole or in part, many of the proposals. Therefore, I shall confine my specific comments to selected sections of S. 1470.

Sections 2, 3, and 4, on hospital reimbursement reform, are aimed at resolving the same critical problem we are all very much concerned about—continued high rates of inflation in health and hospital costs.

To move toward resolution of that problem, the Blue Cross Association strongly believes there is immediate need for enactment of a program to contain costs in the health care delivery system.

Walter J. McNerney, President of the Blue Cross Association and representing Blue Cross Plans, believes that a program of cost containment should consist of two parts: (1) a program to limit hospital inpatient revenues on a class of purchaser basis with positive incentives for hospitals, and (2) a national moratorium on new plan capital expenditures.

As Senator Talmadge has pointed out, Sections 2, 3 and 4 do not represent an immediate program to contain health care costs. We also recognize that there

is a current lack of sufficient knowledge about how to design hospital incentive payment methods and other cost containment tools to achieve more lasting and effective results in moderating health care cost inflation.

Section 2, as presently drafted, would not be effective for some time; it would at first apply only to hospital inpatient routine operating costs, only directly to the Medicare and Medicaid programs, and only to participating hospitals not otherwise determined to be located in an underserved area. Based on those characteristics and certain others, Section 2 would not be the type of revenue limitation program which is needed for the short-term to moderate health care cost inflation while longer term, more permanent cost containment approaches evolve. We do believe, however, that certain concepts in Section 2—such as hospital grouping and incentive payments to a hospital by Medicare and Medicaid where its inpatient revenue increases are below the established annual limit for those classes of purchasers—might be considered in the design of a revenue limitation program that could have short-term results.

A number of concepts in Section 2 might ultimately prove to be appropriate to the design of longer term, permanent reform measures in how hospitals or other health care providers should be paid. However, there have not been enough numbers and varieties of prospective or other incentive payment approaches tried and evaluated to determine whether the type of target-rating approach proposed in Section 2, state hospital rate regulatory mechanisms, or any other specific approach represents the best alternative for the long term. A flexibly designed and administered exemption process—within the context of a revenue limitation program—represents, we believe, an opportunity to contain costs while allowing hospitals, payor groups, and others to respond to incentives in the design of payment systems.

We believe there is also a second key component of a cost containment program—a national moratorium on new plant capital expenditures. It can provide some “breathing room” for new state and local planning agencies, now in a critical stage of development, to formulate health care plans for service needs and project review criteria and procedures in an effective way. Also, it will help to insure that providers of services not covered under a revenue limitation program do not unnecessarily duplicate facilities and services of those subject to a revenue limitation program; or that providers themselves, subject to the revenue limitation, do not move services into otherwise uncontrolled settings.

We urge incorporation of such a moratorium into Section 4 of S. 1470, Federal Participation in Hospital Capital Expenditures, until such time as decisions are reached on any fundamental and permanent reforms to Public Law 93-641, such as the types of capital expenditure limitations currently being proposed in other federal legislation.

We are pleased to see that Section 3, Payments to Promote Closing and Conversion of Underutilized Facilities, has been carried over from last year. It represents the type of positive approach we believe is necessary to help solve problems of excess operating capacity within selected health care institutions. For similar reasons, our reactions are highly favorable to the new “swing-bed” proposal contained in Section 20 of this year’s bill.

I would like to now present some more specific reactions to various sections.

SECTION 2—CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

We like an approach that uses incentives to promote change and improve hospital efficiency. Similarly, we like the emphasis that S. 1470 gives to incentive payment tied to prospective payment. Peer groups and prospective target levels for them can be important in determining incentive payments for good performance and penalties for excessive costs. Furthermore, these concepts would give that reimbursement system a sensitivity to individual hospital characteristics. Such a system would contribute fairness to hospital reimbursement and would recognize the necessary cost of patient care.

We support the provision for accounting and uniform functional cost reporting. This change from the wording in S. 3205 recognizes that uniform accounting is not practical, with the diversity of hospitals and their management practices and needs. A uniform accounting system could be costly to use and could even contribute to inefficiency where the proposed accounting system is not responsive to management practices to achieve uniform functional cost reporting. The responsibility appropriately belongs to the provider to assure that the uniform

reports are correctly prepared and that a proper audit trail exists. However, to be effective, we agree that uniform reporting must be supported by detailed descriptions of the cost and revenue elements which compare each function of the uniform report.

As we said in our testimony last year, no one best performance based payment system has yet emerged. We recognized the problems in the development of an effective cost containment program. It is easier to see flaws than to develop and recommend an alternative that is free of major faults.

In our review of S. 1470, we are concerned about several specific aspects.

Range of costs to be covered

Section 2 covers only routine operating costs adjusted for capital and other cost pass-throughs. Ancillary costs, education and teaching costs, malpractice insurance expense and energy costs are excluded. In very large hospitals, perhaps 80 percent of total costs may be excluded; for all hospitals combined, perhaps two-thirds of all hospital costs would be excluded. Therefore, the impact of Section 2 is limited.

Payors covered

As presently drafted, Section 2 covers only Medicare and Medicaid. As a result, nearly one-half of total payments for hospital care are excluded. While hospitals are prohibited from shifting costs from one payor to another, no means of enforcement is given where the provider, by oversight or intent, disregards this provision.

Peer group

The bill provides for three major categories: acute general hospital care (8 subgroups by size): hospitals associated with medical schools; and specialty hospitals. The classifying system is intended to separate inefficient from efficient hospitals. In the development of penalties and incentive payments in this bill, there is the assumption that inefficient means high cost and efficient means low cost within each category. There is no basis for such an assumption at this time. Unfortunately, there is no known way to classify hospitals by their efficiency. Various systems are being studied. Some ignore size, but consider affiliation and facility characteristics. No system has yet been adequately evaluated and found satisfactory.

In any classification system, more than one hospital may need to be affiliated with a medical school. The larger medical schools frequently have training programs in many hospitals. By limiting the primary affiliation to only one hospital for each medical school, the contractual relations between medical schools and hospitals could be adversely affected. A change in that relationship may result in unexpected consequences to the care provided to patients, including Medicare and Medicaid beneficiaries.

Target levels—average costs

The bill provides for calculating average costs in each peer group on the basis of the sum of two parts: average personnel costs adjusted for area wage differential and average nonpersonnel costs. The adjustment for area wage rates seems intended to make the national peer average applicable to an area hospital. A government study of total hospital costs suggests that wage differentials may not account for all significant variations in cost among hospitals. The adequacy of wage data available for small geographic areas is not yet proven. The provision in the bill that permits a comparison of a hospital wage level with an area wage level may be administratively difficult and expensive even if it is technically feasible.

To implement this provision of the bill, hospitals would have to maintain personnel costs for routine operating costs separately from personnel costs for ancillary and other operating costs. Such allocations are likely to be arbitrary and self-serving.

Penalties for excessive costs

Section 2 does not allow a hospital to be paid more than 20 percent in excess of the average or target level for the group to which it is assigned. Few hospitals may be subject to penalties. Exceptions are granted for hospitals that are in underserved areas or are underutilized and for hospitals that can claim higher intensity of care. The average excludes low cost hospitals which are considered

understaffed. At the option of a hospital, a higher target level in an adjacent size class may be used for its cost reference. No penalty is provided for hospitals that move up within the 100 percent to 120 percent corridor.

Incentives payments

Hospitals whose costs are below the average for routine operating costs receive an incentive payment equal to half the difference between their cost level and the target rate, but not more than 5 percent of the average. There is no incentive to operate below 90 percent of the average. There may be no incentive for a hospital below 90 percent to remain there. As presently written, there is no incentive to improve performance unless a hospital is over 120 percent of the target rate or close to 100 percent of the target rate. The net impact of the incentive payment and penalty provisions may be that total costs will increase.

Utilization impact

Section 2 provides for reimbursement to be based on per diem payments. Utilization control mechanisms have yet to effectively reduce unnecessary utilization. There may be ways to use per diems in a more effective way to discourage unnecessary utilization. For example, Blue Cross of Michigan has designed an alternative that considers volume changes based on a combination of admissions and days of care. This combination could give hospitals a built-in incentive to encourage early discharges.

Impact on outpatient services

As presently written, section 2 excludes ancillary costs from the calculation of target levels. This may encourage hospitals to provide tests and diagnostic services on an inpatient rather than an outpatient basis.

In summary, a bill utilizing the concepts suggested in S. 1470 could have important cost containment impact. Among the features we think are necessary are that it:

1. Cover all hospital costs.
2. Cover all payors.
3. Establish incentive systems that would reward or penalize hospitals along a continuous range of efficiency performance levels and would also reward hospitals for improvements in their performance.
4. Allow for and encourage non-federal, locally developed experimental reimbursement programs.

It would be helpful if the bill required the Secretary to analyze efficiency and inefficiency factors, as related to costs, and recommend to the Congress an appropriate peer grouping system. In addition, a critical need at this time is to identify the kinds of data that will evaluate properly the effects of different cost containment programs. The Secretary should be required to assume the existence of an adequate data base, making maximum use of currently available resources.

SECTION 3—PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

We support the "transitional allowances" provision which will provide temporary financial support to hospitals undertaking closure or conversion of duplicate and unneeded services and facilities. Because the industry's capital structure represents a key determinant of costs, this provision (in combination with P.L. 93-641) represents an innovative step in developing appropriate long-term cost containment measures.

While this provision introduces a novel approach, in need of testing and evaluation, we recommend that the provision be broadened in the following respects.

We suggest that Section 1132(c) (1) and (2) be modified to allow prospective application to the Board. This would provide hospitals considering qualified conversions another incentive—that of financial assurances before the fact.

We also recommend that Section 1132(e) be broadened to provide for more than 50 hospitals during the test. We suggest a minimum of 100, which would provide a broader base for analysis of the provision's impact and give greater latitude to the Secretary to accelerate application of the program on the basis of favorable test results.

Last, in terms of general modifications, we urge that the Board be given more latitude in making its determinations. While the Board should take into consideration planning agency findings under Section 1523 of Public Law 93-641, Section 1132(b)(2) is too restrictive in requiring the "Board decision to be consistent with the findings of the appropriate health planning agency." Although consultation with local planning agencies is essential, we suggest that this section be rephrased to, "Such determinations will be made by the Board only after consultation with and advice from the appropriate health care facility planning agency." This language would clearly establish the Board as the decision-making authority.

In terms of technical modifications, we recommend that the reimbursement provisions, which are different in the cases of hospitals that close and those that remain open, be dealt with in separate provisions for purposes of clarity.

As Section 1132(b)(3) currently reads, several issues are unclear. For instance, in the case of conversions, where the aggregate reimbursement is reduced, would the facility continue to receive any amount of the reduction? If so, does that amount include operating costs or just capital costs such as interest and depreciation? And where operating costs increase on an "interim basis," should time limits be specified for the "interim basis"?

In the case of complete closure, it appears the facility only receives a transitional allowance for debt obligations. We suggest that operating costs associated with the closure also be included.

SECTION 4—FEDERAL PARTICIPATION IN CAPITAL EXPENDITURES

We strongly support capital expenditure limitations and controls to achieve both a short and long-term effect on rising health care costs.

While Section 4 of the proposed legislation attempts to address important aspects of this issue by further linking Medicare and Medicaid reimbursement to Public Law 93-641 and extending Section 1122 penalties to include direct operating costs associated with capital expenditures, we do not feel that these reforms go far enough, given the magnitude of the health care economic problems currently facing our nation.

We support State Health Planning and Development Agencies (designated under Section 1521 of Public Law 93-641) serving as Designated Planning Agencies under Section 1122, the re-establishment of funding to State Health Planning and Development Agencies and Health Systems Agencies under Section 1122, and the extension of Section 1122 penalties to include direct operating costs of unapproved projects.

With respect to capital expenditures of providers located in inter-state SMSA's, we have several questions and concerns. What happens in an SMSA which infringes upon two or more jurisdictions, one of which is not an 1122 State? Assuming the State Health Planning and Development Agencies will be asked to review proposed capital expenditures in such areas, will the Secretary reimburse the non-1122 state for the cost of a review of a project located in a neighboring 1122 state? If the facility proposing the capital expenditure is located in an SMSA, but in a non-1122 state, can reimbursement be limited to the facility because the non-1122 state SHPDA concurs with a negative finding by a neighboring 1122 state, part of which is also in the SMSA? Is it the intention of this provision to extend 1122 authority to cover facilities in non-1122 states? Finally, 180 days may not be adequate time for multiple state reviews of projects in SMSA's. Even though a provider may be located in an inter-state SMSA, it is very possible that it serves few people residing in the neighboring state; from an equity standpoint, should such providers be subject to this provision? Finally, is the interstate SMSA problem of such a magnitude that the benefit to the public will outweigh the additional costs and administrative workloads for both states and providers?

As mentioned earlier, we also recommend a national moratorium on new capital expenditures under the Medicare and Medicaid programs until decisions are made on more permanent reforms to Public Law 93-641, such as the capital expenditures limitation contained in Title 2 of S. 1391 and H.R. 6575.

From our perspective, the key provisions of a capital expenditure moratorium include expansion of Section 1122 to include, as covered capital expenditures, major equipment acquisitions regardless of location, e.g., both Part A and Part B participating providers; and the extension of Section 1122 review authority

to all states, regardless of whether or not they are currently participating in the Section 1122 review program.

In state that have a Section 1122 review agreement with the Secretary, the Designated Planning Agency would have the responsibility to administer the transitional moratorium program, including the granting of exceptions. Exceptions in such states should be granted for capital expenditures approved by the DPA prior to the date of enactment of the moratorium. After that date, exceptions may be allowed for capital expenditures necessary to eliminate or prevent imminent safety hazards as defined by federal, state or local fire, building or life safety codes or regulations; or to avoid non-compliance with state or voluntary licensure or accreditation, if the health services for which the capital expenditure is proposed are needed, as determined by the Designated Planning Agency.

The moratorium program should also be applied in states that have not entered into a Section 1122 review agreement with the Secretary. In such states, Medicare intermediaries would monitor capital expenditures made by participating providers and report violations of the moratorium program to the Secretary.

In such states, the Secretary, or his designee, should administer exceptions to the moratorium program. Exceptions would be granted for capital expenditures that have been obligated or approved by an existing state certificate-of-need program prior to the date of enactment of this program; or, have been determined to be needed by an existing conditionally or fully designated state health planning agency or health systems agency and are necessary to eliminate or prevent imminent safety hazards.

The Secretary would be required to establish procedures governing both the review of exception requests and appeal of exception decisions.

We recognize that there are some problems associated with application of a capital expenditures moratorium program to Part B providers; we would be pleased to work with congressional staff and others on this issue.

SECTION 12—HOSPITAL ASSOCIATED PHYSICIANS

We agree with the provisions in Section 12 that limit physician billing to patients to situations where they have rendered the services directly. Such provisions can provide a basis for realistic evaluation of the costs associated with this important component of health care cost.

We have concerns about the specific provisions limiting physician reimbursement on the basis of its being a "volume related" arrangement because:

1. they are based on the form of the transaction rather than on the result (how much was paid for what services). We believe an arrangement for payment based on volume can produce a reasonable level of compensation. On the other hand, salary or other non-volume arrangements could result in unreasonable levels.

2. they could result in physicians entering into direct billing arrangements. Such arrangements, with a separate contract for administrative functions, would result in an increase of cost to Medicare.

Limitations on revenue or cost should not be related to form or process, but should relate to the result. Furthermore, changes in this area should be considered in the context of a long-range cost containment program which considers providers' total costs and revenues.

In this connection, we believe the following suggestions would make administration of the program easier, assure that payments to physicians are appropriate and reduce the fragmentation of payment choices that now exist for hospital and medical services:

1. Require that Medicare program payments to all hospital associated physicians be made through the provider. This would require that all physicians bill for their services on a "combined billing basis" if they do not directly relate to the patient and do not have a "private patient relationship."

The provision would apply most frequently to radiologists, pathologists, cardiologists, and emergency room physicians. Splits between Part A and Part B Trust Funds could be made at the end of the year based on the provider cost report.

2. Add provisions to assure that payments and increases in payments by providers to physicians are appropriate. The provisions should: focus on the total amount paid to the physicians rather than on the type of arrangements; establish an acceptable rate of increase, published in advance; and be consistent with the overall cost containment program adopted.

Any changes made in the reimbursement for hospital associated physicians under this legislation should be monitored carefully and evaluated so that the impact is consistent with the intent of the law.

SECTION 20—HOSPITAL PROVIDERS OF LONG-TERM CARE

We support the provisions in Section 20 that encourage acute care hospitals provide skilled extended nursing care to fully utilize existing facilities while appropriately meeting patient care needs. We are particularly pleased with the provision for evaluating the impact of such change on utilization.

Although experiments have occurred in which some acute care hospitals have made beds available for such care, these experiments have not been in effect long enough to permit a satisfactory evaluation. The promise is such that we urge that Section 20 be modified to permit greater access to the possible benefits of the program and to provide a broader base for program evaluation. In that connection, we suggest:

(1) The bed size limit be set at 100 beds or less. This change will include a number of hospitals and communities which could effectively benefit from this provision.

(2) Permit planning approval by appropriate planning agencies in the community. As presently written, this section appears to limit planning to federally approved Certificate-of-Need agencies under Public Law 93-641. This is too restrictive, since there are no such agencies currently in operation.

SECTION 33—REPEAL OF SECTION 1867

We believe that HIBAC, or a similar mechanism, should continue to exist. There is a need for a strong and effective, broad-based external advisory body which can provide important points of view to the Secretary at the critical stages of Titles 18 and 19 development and administration. Titles 18 and 19 represent major public programs which affect many citizens, and careful consideration should be given to HIBAC membership and representation to improve its performance.

SECTION 43—WAIVER OF HUMAN EXPERIMENTAL PROVISION FOR MEDICARE AND MEDICAID

We are unsure of the exact intent of this provision and recommend further clarification. To our knowledge, there are no legislative requirements in Title II of Public Law 93-348 that preclude cost-sharing. Even if cost-sharing is precluded in related rulemaking, we are still uncertain as to what is really being accomplished in this provision.

SECTION 44—DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

We believe in disclosure of information necessary to increase public awareness of key aspects of health care financing and delivery.

Although much of the information in the news media pertaining to physicians who have been paid large amounts of public funds for treating Medicare and Medicaid patients has been incorrect and/or misleading, we urge that some public disclosure continue with better safeguards.

SECTION 45—RESOURCES OF MEDICAID APPLICANT TO INCLUDE CERTAIN PROPERTY PREVIOUSLY DISPOSED OF TO APPLICANT'S RELATIVE FOR LESS THAN MARKET VALUE

We support this provision to prevent fraudulent practices by individuals for purposes of becoming eligible for Medicaid.

However, it is our understanding that a state cannot deny Medicaid eligibility to welfare recipients in the categorical assistance programs such as AFDC or Aid to the Blind and Disabled. If no similar test of property disposal applies to those categorical assistance programs, could a state legally deny Medicaid eligibility, even if this provision were enacted?

In addition, we urge caution with respect to enactment of a provision which as it currently reads, might not require states to look at individual circumstances, e.g., whether there were valid reasons for someone to dispose of property with no intent to defraud, and whether the person has retained actual use of the disposed property.

We are also unclear as to the exact definition of "property" for purposes of this proposal and recommend clarification.

SECTION 46—RATE OF RETURN ON NET EQUITY FOR FOR-PROFIT HOSPITALS

Section 46 would allow a higher rate of return on equity capital for for-profit hospitals. We believe it would be inappropriate to provide such an increase. There is no reason to provide incentives to invite capital into the industry at this time. On the contrary, there is public concern about overcapacity. S. 1470 recognizes this concern in two major provisions that relate to closing or correcting unneeded or excess capacity.

Given the present tax structure, the primary effect of an increase in the return on equity would be a transfer from the Medicare-trust funds to general revenue funds. Such a shift would do little to affect access to or quality of care and is inappropriate in view of concern over the cost of health care.

On the other hand, Paragraph (3) of this section, which appears to eliminate any return on net equity for for-profit hospitals after 1980, is unfair. Legislation should not deny providers a right through the reimbursement system to earn any excess over accounting costs. Investors should be able to receive a return on their investment. To do otherwise would effectively eliminate this important segment of the industry.

Mr. Chairman and Members, I thank you sincerely for giving me the opportunity to present the views of the Blue Cross Association and of our entire organization of Plans on these Medicare and Medicaid reforms.

If you have questions about anything I have said, I would be glad to answer them now. If you need further information that I do not have with me, we will be pleased to provide it as quickly as possible.

Thank you very much.

Senator TALMADGE. In view of the fact that Senator Dole must leave at 10 o'clock, we will hear from Mr. A. B. Davis, Jr., next, executive vice president and chairman, Board of Directors, Kansas Hospital Association.

Senator DOLE. With him is Frank Gentry, executive director of the Kansas Hospital Association.

Senator TALMADGE. Welcome, gentlemen.

STATEMENT OF A. B. DAVIS, JR., EXECUTIVE VICE PRESIDENT AND CHAIRMAN, BOARD OF DIRECTORS, KANSAS HOSPITAL ASSOCIATION, ACCOMPANIED BY FRANK L. GENTRY, EXECUTIVE DIRECTOR, KANSAS HOSPITAL ASSOCIATION

Mr. DAVIS. Thank you very much, Mr. Chairman. We are here to represent the Kansas Hospital Association and speak for its 165 member hospitals. These institutions range in size from a 12-bed hospital providing primary care in an isolated small rural community to a large medical center in our metropolitan area having more than 700 beds. A wide gamut of hospital services are provided by our membership, and each and all of our hospitals are vital links in the health care chain in Kansas.

We are grateful for this opportunity to speak on behalf of our members concerning the Medicare-Medicaid Administrative and Reimbursement Act, S. 1470.

It is fitting that after a decade, title XVIII and title XIX of the Social Security Act should be reviewed and those portions that have become burdensome and unworkable should be excised and replaced with more efficient and economical provisions. These programs for providing high quality health care for Kansas, and all Americans,

have become an integral part of our national priorities and must continue to be available to the aged and indigent ill and injured.

Mr. Chairman, it is reassuring to know that you and the other cosponsors of this bill have introduced legislation that recognizes the complexity of the administrative and reimbursement mechanisms in the medicare and medicaid programs, and have refused to offer simplistic short-term solutions to the problems that have evolved over the years.

This committee, in recent history, has been inundated with facts and figures about reasons for rising health care costs and the measures that hospitals are taking to curtail costs. We will not repeat these for you at this time. Nor will we comment on other legislative proposals that advocate additional controls on the hospital industry. Since the American Hospital Association has provided you with their comprehensive section-by-section discussion of S. 1470, we will limit our remarks to those two sections of the bill we perceive to have the greatest impact on Kansas hospitals.

Before we begin our discussion of S. 1470, we would like to make a few general comments. Lids and ceilings on hospitals alone are ineffective because they address only one of the individual "actors" in the health care drama. Continued increases in the cost of health care are the composite of individual decisions made by hospital administrators, physicians, Blue Cross, commercial insurance companies, Federal government officials, State government officials, union and management labor negotiators, suppliers, and the general public.

Only as these individual actors become increasingly cost conscious and make cost effective decisions will health care cost increases be abated.

The proponents of caps on hospital costs apparently feel that the only individuals making decisions affecting hospital costs are those people responsible for the management of hospitals. This simply is not the case.

As noted earlier, many parties—including physicians, commercial insurance companies, the general public, and the Government—daily make decisions that ultimately result in increases in hospital costs. For any governmental cost control program to be effective, it must address all of these decisionmakers, instead of forcing restraints on one actor, whether that is a hospital manager or the Federal reimbursement system.

Even if Congress develops an incentive reimbursement system that rewards efficiency and punishes inefficiency, and even if hospitals are as efficient as ultimately possible, the following factors continue to exist: (1) Insurance policies tend to encourage inpatient hospital utilization; (2) private individuals do not share the financial risk of their decision to enter hospitals; (3) the Federal Government mandates unnecessary and expensive regulations; (4) the cost of goods and services hospitals must purchase continues its upward trend; and (5) people continue to persist in self-indulgent lifestyles.

Mr. Chairman, it is obvious that the portion of the current version of the Medicare and Medicaid Reform Act which will impact most significantly on hospital operations is section 2 relating to hospital reimbursement reform. The Kansas Hospital Association agrees that there are a number of significant changes in institutional reimburse-

ment that can and should be made in the medicare and medicaid programs. The reimbursement changes embodied in S. 1470 appear to be an improvement over the existing methodology employed in the administration of section 223 of Public Law 92-603, which we understand section 2 is designed to replace.

We must point out, however, that any system designed to classify institutions for the purpose of limiting reimbursement due to institutional comparison has certain inherent difficulties. A classification system must be sufficiently sophisticated so as to separate efficient from inefficient institutions. The system should be designed so that efficient hospital operations do not find themselves penalized because of inappropriate classification determinations.

We, in Kansas, are concerned that too much reliance on bed size in a classification mechanism may not be wholly appropriate. For example, the major hospital center for the southwestern portion of our State is a 191 bed hospital. This institution could very well have a much more complicated case mix and totally different kinds of admissions than would a similar sized general hospital located in the suburbs of a major metropolitan area.

We are also concerned about the provisions of the reimbursement section of the bill that call for the adjusting of average per diem routine operating costs through the use of the wage index based on general wage levels prevailing in the areas in which the hospitals are located. Such indices are not available for that large portion of our State which is rural.

Only 8 of the 105 Kansas counties fall within standard metropolitan statistical areas. We are concerned also that the index refers to wage levels in the general economy rather than that segment of the labor force from which hospitals recruit their employees. In Kansas, such an index would have to reflect the predominate nature of agriculture on our economy and would not accurately reflect the highly specialized employees required in today's modern hospitals.

We support the efforts in S. 1470 to remove from the routine per diem hospital cost comparison procedure a number of elements which are beyond the control of the individual hospitals. This, of course, will serve to ameliorate many of the problems inherent in previous classification systems. The Kansas Hospital Association, however, feels that there is another reimbursement system which would be preferable. It is the opinion of KHA that the best vehicle for long range reimbursement reform is through budget and rate review of individual hospitals. Rate review commissions created by statute in several of the States have demonstrated their ability to hold the increase in hospital charges to below the national average. In Indiana, where a voluntary program has been in effect since 1959, the same record of cost savings has been demonstrated. We would envision that such rate setting mechanisms could be established in individual States, by State statute or through operation by major third party payers such as Blue Cross-Blue Shield as is the case in Indiana.

A viable prospective rate review system must focus on total costs; the rates determined must be applicable to all payers; and participation in them must be mandatory for all hospitals.

We feel it is imperative that prospectively determined rates apply to all third parties to avoid subsidization of one group of patients by

another. This in itself will have the effect of moderating increases in hospital costs as are reflected by the hospital service charge index of the Consumer Price Index.

Reform mechanisms must be designed so as to protect the financial integrity of the medicare and medicaid programs. Broad minimal Federal guidelines should be developed which include: (1) Which costs are allowable; (2) requirements for statewide rate review systems; (3) recognition of the full financial requirements of hospitals; (4) the implementation at the State level of existing cost control concepts, such as the planning process created by Public Law 93-641 and the utilization review/PSRO mechanisms; (5) the establishment of adequate appeal procedures to insure due process; and (6) provisions requiring the State regulating body be an independent agency whose sole responsibility would be the regulation of the rates of health care providers.

This agency should specifically be prohibited from acting as a purchaser of care, provider of care, or regulator of any other aspect of health care; for example, capital expenditures or licensure.

Mr. Chairman, our second major concern relates to long-term-care reforms. While we support the provision of S. 1470 dealing with the swing bed concept, we feel it omits discussion of one area of concern causing significant problems to hospitals providing long-term-care services.

In Kansas, we have 30 institutions that have attached long-term-care facilities. In these combined facilities, the general services such as administration, business office, laundry, medical records, housekeeping, maintenance of the plant, and education are shared between an acute hospital and an attached nursing home unit. Serious problems have developed due to the treatment of these facilities by both the certification and reimbursement processes.

The combination method of cost finding for hospitals with attached long-term-care facilities is inequitable in that costs which should be allocated to the acute hospital are, under the current system, being allocated to the long-term-care unit. This process results in large amounts of money being denied to the hospitals for valid costs which they have incurred.

Many hospitals in Kansas that are trying to provide this service lost as much as \$100,000 per year because of the unjust reimbursement system. We understand that this simplified cost finding will not be required in the future, but the departmental cost finding that will take its place, although an improvement, will not be sufficiently flexible to deal with the special problems of these combined units. Inequities will still exist.

Major problems are present regarding the certification of these facilities. The conditions of participation for both hospitals and skilled nursing facilities and the certification standards of intermediate-care facilities are written in anticipation of the surveyor encountering a free-standing institution.

The surveyors are not prepared, or does the survey process allow, for these combined facilities.

The Kansas Hospital Association therefore strongly recommends that a new section be added to that portion of S. 1470 relating to

long-term-care reforms that would require the Secretary of Health, Education, and Welfare and the Health Care Financing Administration to develop flexible cost-finding procedures that can be utilized to accurately allocate expenses between hospitals and their attached long-term-care units. The Kansas Hospital Association also recommends that a special section be created in the conditions of participation for hospitals and certification requirements for nursing homes to regulate the operation of these shared units.

The hospitals of Kansas appreciate this opportunity to present our statement on S. 1470 and we will be happy to respond to questions of the committee.

Senator TALMADGE. Thank you, sir.

Senator Dole?

Senator DOLE. With respect to the last page, when the staff read this prepared statement they noted the recommendations on how to improve the current certification process for hospitals that also provide long-term-care services. It seems logical to me that since hospitals providing long-term-care services share most of the resources of the combined facility, it would be appropriate to recognize this situation and the regulations for hospitals rather than apply two separate sets of regulations, one for hospitals and one for long-term-care facilities.

I have been advised by the staff that your recommendations can be accomplished administratively by HEW. Mr. Chairman, I would suggest that this subcommittee send a request to the Secretary asking that the recommendations of the Kansas Hospital Association be adopted.

Senator TALMADGE. Without objection, so ordered.

Senator DOLE. Dr. Davis, you point out in your statement on page 5 that prospective determined rates for reimbursement should be applied to all payers. I understand, then, you would support enlarging the Talmadge bill to cover everyone?

Mr. DAVIS. Yes, Senator, we would, definitely.

Senator DOLE. Also, on page 4 of your statement you note your concern regarding the classification mechanism for hospitals. I think we also recognize that bed size is only one component that must be considered. I think that is clarified on page 4, line 18, of the bill. I am I am not certain you have the text of the bill.

If, after reviewing that and other provisions, specific provisions of the bill, you think there should be further modification, we would be happy to have that.

Mr. DAVIS. Thank you, Senator. We will review that more carefully and submit further testimony.

[The following was subsequently supplied for the record:]

THE KANSAS HOSPITAL ASSOCIATION,
Topeka, Kans., July 15, 1977.

SENATE COMMITTEE ON FINANCE,
Dirksen Senate Office Building,
Washington, D.C.

DEAR SIRS: The Kansas Hospital Association is appreciative of the opportunity to further elaborate on two portions of our earlier testimony on the Medicare/Medicaid Administrative and Reimbursement Reform Act, S. 1470.

The section relating to the classification of hospitals in S. 1470 notes that hospitals were to be placed in groups by bed size, type of hospital, or categories found to be appropriate. During the testimony of the Kansas Hospital Associ-

ation on S. 1470, the Medicare and Medicaid Reform Act, Mr. Jack Davis, Chairman of the Board of Directors of the Kansas Hospital Association, was asked to provide suggested changes to the section that would eliminate our concerns about the proposed classification methodology.

The Kansas Hospital Association will not propose a full classification system, but will rather identify some of the elements that need to be considered in order for a classification system to achieve maximum equity. Those elements that need to be addressed are:

1. *Bed size.*

2. *Hospital location.*—The methodology utilized could be the same as is now being utilized under Section 223 of P.L. 92-603 which involves a Standard Metropolitan Statistics Area (SMSA) or a non-Standard Metropolitan Statistics Area designation. Or a classification system could use other appropriate measures to separate urban from rural facilities.

3. *Scope of Services.*—Such an element is necessary so as to identify and treat together, as much as possible, hospitals with attached long-term care units; hospitals involved with teaching programs; hospitals offering an unusually wide range of services for their size. An example of this latter circumstance might be a relatively small osteopathic hospital, working in conjunction with a college of osteopathy, that offers a much broader range of services than a normal hospital of similar size.

4. *Length of stay.*—This factor must be considered because of its impact on the intensity of services rendered during a hospital admission. Hospitals with shorter stays often provide more intense (compact) services in a shorter timeframe, thus their cost per day is higher.

5. *Patient mix.*—This element in some ways overlaps other categories, but a 150 bed hospital that is a medical center for a large rural area could have a considerably different patient mix than a similar sized hospital that is located on the outskirts of a metropolitan area with several large teaching institutions.

6. *Demographic characteristics of the hospital's service area.*—This element is quite complex. One such factor that must be considered is the average wage levels in different communities. A 75-bed hospital just outside of a metropolitan area, that is required to compete with that metropolitan area on a wage basis would have substantially higher wage costs than would a 75-bed hospital in western Kansas. The impact seasonal farm workers have on the average wage level should also be considered.

Another demographic measure would be the age composition of the population in a hospital trade area. A facility serving an area of predominately elderly people could need vastly different kinds of services and thus incur higher costs than a hospital serving a relatively young and healthy population.

The final demographic factor that would need to be considered could be related to climate or special regional circumstances. The problem of the upper respiratory ailments of coal miners, and dust-related problems found in the Great Plains states, and the especially high energy costs in the extreme northern states need to be taken into account in some way.

All of the above listed elements need to be studied and their relative impact of each on hospital costs must be taken into account in the development of a classification system. The omission of several of these elements has the potential to create severe inequity.

The second area that the Kansas Hospital Association was requested to provide additional information on concerned the problems currently being experienced by those Kansas hospitals which currently operate attached long-term care facilities. In our testimony two major problems with these units were identified and discussed. The first of those, relating to certification problems of the combined units, was addressed in the June 14, 1977 letter to the Health, Education, and Welfare Secretary Joseph Califano, Jr. from Senators Talmadge and Dole. If the Secretary implements the request of the Subcommittee on Health of the Senate Finance Committee, the certification problems now being experienced should be eliminated. The Kansas Hospital Association wishes to thank the Subcommittee on Health for their assistance in helping resolve this problem.

The second problem of these combined units relates to reimbursement problems. In the testimony of the Kansas Hospital Association before the Subcommittee, we fully explained the problems with the current cost allocation processes in the Title XVIII and Title XIX reimbursement systems. We will not repeat this explanation at this time but will attempt to provide specific recommendations as to how this might be remedied.

On Friday, November 26, 1976, the Bureau of Health Insurance published in the Federal Register proposed regulations designed to eliminate the Combination Method of cost apportionment from Medicare cost-reporting periods starting after December 31, 1977. The proposed regulations would allow all hospitals, irrespective of size, to utilize the more sophisticated Departmental Method of cost funding. The Kansas Hospital Association strongly supported such a change. It has been our experience in Kansas, as is the experience nationwide, that hospitals are able to easily meet the necessary statistical requirements of the Departmental Method of cost apportionment. We further urge that these proposed regulations be adopted in their final form as soon as possible. It was our hope at that time that final regulations would be published early enough to allow hospitals with June 30, 1977 year-end closing dates to be able to use the Departmental Method of cost apportionment. Many of our Kansas hospitals, in anticipation of this proposed change, are already keeping the necessary statistics and thus will be prepared to use the Departmental Method of cost apportionment for the current fiscal year.

To date the final regulations have not been published. This delay has been very costly to Kansas hospitals. The Kansas Hospital Association would appreciate the assistance of the Senate Finance Committee in securing the immediate publication of these final regulations.

Although the elimination from the Combination Method of cost apportionment and the resultant requirement that all facilities use the more sophisticated step-down Departmental Method of cost apportionment methodology, which is a step in the direction of more equitable cost apportionment, we urge the subcommittee to remember that this is only the first of what needs to be a series of many steps.

Departmentalized cost apportionment still requires standard apportionment bases and that in the instances of combined hospital and long-term care units may not be appropriate in determining exactly the true cost of operation for each separate component of the institution. We would recommend that both the Health Care Financing Administration and the staff of the Subcommittee on Health of the Senate Finance Committee continually monitor the effects on equity of hospital reimbursement of the various apportionment methodologies. It is imperative that enough flexibility be provided in the apportionment process so that institutions that embark upon new and innovative kinds of services, in order to better serve their client population, not be penalized in the apportionment process. If departmental cost apportionment still results in a disproportionate share of total facility costs being allocated to the long-term care unit, we urge that the Health Care Financing Administration be directed to publish regulations that would allow for the utilization of alternate apportionment bases. These would need to be sufficiently specific so as to allow the use of only those bases which would allow for more equitable cost finding. This process should not ever be allowed to result in an unwarranted run on the financial resources of the federal health care programs.

In summary, the Kansas Hospital Association urges that the Subcommittee on Health direct the Health Care Financing Administration to publish as soon as possible its regulations eliminating the Combination Method of cost apportionment; and secondly, that for hospitals operating combined units, that alternative allocations be considered so that the true costs of operation are identifiable.

The Kansas Hospital Association again thanks the Subcommittee on Health of the Senate Finance Committee for this opportunity to provide additional testimony on the Medicare/Medicare Administrative and Reimbursement Reform Act, S. 1470. We are prepared to answer any further questions the Subcommittee might have.

Sincerely,

FRANK L. GENTRY, *President.*

Senator DOLE. Then with reference to the need to have area wage indexes as an important element in adjusting for differences in hospital costs, I assume that your concern is with the present lack of proper indexes rather than opposition to using them where they reasonably reflect differences in wage levels. That is correct?

Mr. DAVIS. That is correct, Senator. That is the problem.

Senator DOLE. Perhaps that can be addressed appropriately.

You have also heard the previous witness from AMA with reference to errors in releasing physician's payments under medicare.

The chairman has indicated, of course, the primary concern is full information and accuracy. I think that has occurred, and you expressed to me, I think that if we can be assured of accuracy and that the information is full and complete I do not think anybody objects to the information being released.

Mr. DAVIS. Exactly.

Senator DOLE. I thank you, Dr. Davis, for appearing. I think it does give us some insight into a little different mix because Kansas has, as you indicate, from 12 beds up to 700 beds.

Do I, finally, understand from your statement that you support using some of the unused capacity in hospitals for extended care?

Mr. DAVIS. That is correct, Senator.

Senator DOLE. Do you see any problems there? We had some indication that there may be a problem of conversion and then converting back.

Mr. DAVIS. I want to ask Mr. Gentry to speak to that.

Mr. GENTRY. Mr. Chairman and Senator, we do sense some problems. As you recall, we have been dealing with it ever since 1966. The swing bed concept, I think, will help most of our hospitals. There are 150 hospitals. All but 30 of those are strictly hospitals. The other 30 where they try to meet a community need by adding a longterm care unit within the hospital or within the facility have suffered some difficulties that the swing bed concept per se will not solve.

They have been successful in meeting the need. They have benefited the community but have been penalized by the medicare reimbursement system.

You mentioned it could be handled administratively and I hope it can. A few years ago, you did help us in an instance where there was a serious situation for a county hospital that had approximately the same number of acute beds and the same number of longterm care beds.

The bottom line of the reimbursement formula for that hospital was penalized very significantly, by reason of the formula. It can be handled. That particular one was solved, but not for the overall mixture. We need to work with the Department on that.

I am very pleased that you made that recommendation.

Senator DOLE. Thank you very much.

Senator TALMADGE. Thank you very much, gentlemen, for your constructive contribution.

The next witness is Mr. Richard E. Murphy, legislative director, Service Employees International Union, AFL-CIO.

Mr. Murphy, we are delighted to have you sir. You may insert your full statement in the record and summarize it in 10 minutes, if you will.

Mr. MURPHY. I regret our secretary-treasurer is not here to testify. He is ill, that is why I came in his place.

Our research director, Stanley Wisniewski, will offer our testimony.

We represent almost 200,000 hospital workers across the United States, plus 400,000 in private industry. We think that your legislation as drafted needs some substantial revision to protect the members that we represent, as well, as we think, the other workers in the hospital who, by and large, are low paid.

Mr. Wisniewski will elaborate.

**STATEMENT OF RICHARD E. MURPHY, LEGISLATIVE DIRECTOR,
SERVICE EMPLOYEES INTERNATIONAL UNION, ACCOMPANIED
BY STANLEY WISNIEWSKI, RESEARCH DIRECTOR, SERVICE EM-
PLOYEES INTERNATIONAL UNION**

Mr. WISNIEWSKI. Thank you, Mr. Chairman.

As Mr. Murphy said, we represent over 200,000 health care workers. In addition, we represent another 400,000 workers in private industry and in the public sector.

All of the workers we represent are seriously affected by the problem of health care inflation. Many of our members are low-wage service workers and consequently find it difficult to deal with the high cost of medical care. Ironically, among the workers hardest hit by medical care inflation are health care service workers whose wages still remain below the level of earnings enjoyed by workers in most other sectors of the economy.

The average nonsupervisory hospital worker earned \$4.18 an hour in 1976—a rate lower than the average wage earned in the private sector, in manufacturing, or in the private economy taken as a whole. Most health care workers, nurses, nurses' aides and service workers, are inadequately paid and find it difficult to shoulder the burden of rising health care costs. Based on a 40-hour week, the average nonsupervisory worker's annual salary in 1976 would have approximated \$8,694. By comparison, in autumn 1976, the U.S. average cost of the lower budget for an urban family of four was \$10,041 a year, while the intermediate and higher levels were \$16,236 and \$23,759 respectively.

As a result of the inadequate wages received by health care workers, the gap between their earnings and the price of medical care has widened over the years. During the past 10 years, hospital room rates have risen nearly twice as fast as hourly wages. Therefore, we welcome initiatives aimed at moderating the rise in health care costs but we are strongly opposed to any program that would interfere with free collective bargaining in the hospital industry or hold down the wages of hospital workers. We believe that to be effective, a health care cost containment proposal must address the real cause of inflation—mismanagement, poor planning, and wasteful duplication of services—rather than impose additional hardships on already poorly compensated wage earners.

Hospital workers are the victims, not the cause, of medical care inflation. The rapid increases in the cost of medical care are not attributable to nonsupervisory labor costs. Over the past 15 years, less and less of the hospital dollar was spent on labor costs each year. This trend is remarkable in view of the ever-rising demand for more and better skilled health care workers employed in hospitals increased from 1,763,000 in 1962 to 3,023,000 in 1975 and the number of workers per 100 census—average daily hospital census—more than doubled to 269 employees per 100 census. In addition, the types of health care workers and the skills they possess have been dramatically upgraded with the introduction of new paraprofessional and technical positions. Yet, notwithstanding these huge increments in both the quantity and

quality of hospital manpower, payroll expenses have steadily declined as a proportion of total hospital expenses from 66.5 percent in 1962 to 51.1 percent in the last quarter of 1976.

Total labor costs in the hospital industry now account for a little more than half of operating costs and the salaries of administrative and supervisory personnel account for roughly one-third of these labor costs. In other words, nonsupervisory and nonadministrative labor costs currently absorb approximately 35 percent of total operating costs.

The available evidence clearly demonstrates that nonsupervisory labor costs, whether union or nonunion, had little to do with inflation in health care prices. For example, the Council on Wage and Price Stability recently released a study which estimates that limiting the rise in the rate of earnings increase of hospital employees to the increases experienced by all private nonfarm production workers over the 1955-75 period would have only reduced the annual rate of increase in average cost per patient day from 9.9 percent to 8.8 percent. In other words, total labor costs were the source of only about one-tenth of the annual increase in hospital costs.

Other recent studies of hospital worker wages which focus on only collectively bargained wages indicate that the union impact on hospital costs appear to be in the range of 1 to 2 percent. Moreover, while unionized hospitals pay higher wages, they may experience lower labor costs because, unlike their nonunion counterparts, they are troubled less by high labor turnover rates.

With about 18 to 20 percent of all hospital workers organized and with total payroll costs representing roughly 51 percent of operating costs, organized labor accounts for only 10 percent of hospital costs. Clearly, this is too small a portion to have had a significant impact on health-care inflation.

Collectively bargained wage increases in the health care industry have not been excessive as indicated by the data provided in the appended table II. The average increase which became effective during 1975, in SEIU contracts was 7.8 percent, while for 1976, the average increase was 7.1 percent.

To date, in 1977, those increases which have occurred or are expected to occur on the basis of previously negotiated settlements average 7.1 percent. These increases can hardly be termed excessive inasmuch as the effective wage rate changes reported by the Bureau of Labor Statistics for wage settlements in the private sector as a whole averaged 8.7 percent in 1975 and 8.1 percent in 1976.

Clearly, labor costs have played a minor role in pushing hospital costs upward. Health care workers are the victims of rising health costs as much as anyone else, or perhaps even more so, since they are less able to afford such price increases. Workers engaged in manufacturing earn at least a full dollar more than the average hospital worker. In actual dollars and cents, hospital workers gained only \$1.39 in increased hourly wages since 1970, while the average worker in the private sector increased his earnings by \$1.65. Therefore, we find S. 1470 highly objectionable because it unfairly places the burden of controlling hospital costs on the shoulders of low-wage hospital workers.

Section 2(b)(aa)(3)(E) of the proposed legislation erroneously tries to set hospital wages on the basis of comparisons with their counterparts outside hospitals in the same geographic area, when in fact, in most instances, comparable occupations either do not exist outside hospitals or else, do not exist in sufficient numbers to permit meaningful comparisons.

Occupations which make up the bulk—80–85 percent—of the non-supervisory hospital work force such as nurses aides, psychiatric aides, licensed practical nurses, medical records technicians, medical technologists, respiratory therapists, radiologic technologists, admitting clerks, and registered nurses are not found employed outside the health-care industry in significant numbers and, even where they do exist, their job responsibilities are often vastly different. Even in those few instances where comparisons between hospital and general wage levels for a particular occupation can be made, methodological problems such as obtaining data outside major metropolitan areas, timing the collection and analysis of the data to meet the needs of the legislation, collecting accurate fringe benefit data on an annual basis would prove to be a formidable and expensive task for the Government's statistical agencies.

Section 2(b)(aa)(3)(E) of S. 1470 makes no effort to separate wage and salary data for supervisory and administrative personnel from data for nonsupervisory personnel. The net result of this omission is that low-paid nonsupervisory personnel can have their wage increases restricted because they happen to work at a hospital with highly paid administrative personnel.

Section 2(b)(aa)(3)(E) also makes no distinction as to the size of the hospital in making its comparisons. Irrespective of the size or nature of the hospital, occupations are to be compared to the same general area wage levels—completely ignoring the different labor market factors that may impact on each situation.

Notwithstanding all these shortcomings in its proposed mechanism for setting a limit on hospital personnel costs, S. 1470 not only attempts to control wage increase but, after 1979 could form the basis for wage cuts. It is unconscionable to contemplate wage cuts in an industry in which the average nonsupervisory wage already lags behind wages in practically every other major industry and where low-paid workers are hard-pressed to deal with pains of the general rate of inflation.

Furthermore, section 2(b)(aa)(3)(E) provides hospitals with an incentive to continue to increase expenditures in those areas which have been most responsible for health care inflation at the expense of low-paid workers. This terrible state of affairs is precipitated whenever the hospital wage level is below the permissible limit, because irrespective of its actual expenditures for wages the hospital is reimbursed the full permissible limit to the extent that they can lower wages below the amount allocated to them by the personnel cost formula. In short, a hospital is able to shift the burden of the program onto the low-wage workers through a refusal to grant any wage increase.

In view of the fact that wage increases for hospital workers have not been responsible for the rapid rise in hospital costs and that nonsupervisory workers are still severely underpaid, we believe that the system of wage controls advocated in S. 1470 is unjustified, unfair, and un-

workable. Moreover, it represents an unwarranted interference with the rights of hospital workers to engage in free collective bargaining—a right which was finally extended to all private sector hospital workers in the 1974 amendments to the National Labor Relations Act. Therefore, we are adamantly opposed to S. 1470 as proposed. We believe that the wages of these nonsupervisory hospital workers should rightfully be excluded from the scope of this legislation.

As consumers of medical care we appreciate S. 1470's efforts toward establishing a uniform accounting and reporting system, however, at the same time we are dismayed by section 44 which would prohibit the release of the names of physicians who have been paid large amounts for treating medicare patients. It is the lack of information available on provider activities in the industry that encourages abuse. We favor full disclosure for all providers in the health care industry.

On behalf of the members of the Service Employees International Union I thank the committee for the opportunity to present our views.

Senator TALMADGE. Thank you very much for your testimony.

You stated that nonsupervisory wage rates lagged behind wages in practically every other major industry. Elsewhere in your testimony you stated that comparable occupations do not exist outside of hospitals, or else do not exist in sufficient numbers to permit meaningful comparison.

If you say you cannot compare hospital occupations with other occupations, how can you tell us that hospital workers are underpaid?

Mr. WISNIEWSKI. What I mean to say there is the private nonsupervisory hourly rate for all workers in the economy happens to be higher, not only for the total private sector but for service workers included, than the hospital workers average hourly rate.

That is not to say there is comparison between the occupations there, but just to say that the average hourly rate for that industry group as a whole is less than the average hourly rate for the service sector as a whole and for the private sector as a whole. That information is contained in the first table.

Senator TALMADGE. Our subcommittee has no objection to publication of physicians' fees. What we are trying to get at is in the inaccurate publication which has been rampant.

Secretary Califano testified Tuesday and he has pledged to try to correct that. We certainly have no objection to any Federal expenditures being made a matter of public record. We think it should be.

Senator Danforth?

Senator DANFORTH. You are concerned about the increasing costs in health care?

Mr. WISNIEWSKI. It affects health care workers as much, if not more, than other workers, because they have less wages to spend on health care.

Senator DANFORTH. If you were in our shoes, what would you do?

Mr. WISNIEWSKI. We favor the approach proposed in the Health Security bill. We recognize that is a long-term approach. In the interim, we would favor something along the lines of S. 1391, but we have some reservations.

Senator DANFORTH. S. 1391?

Mr. WISNIEWSKI. The administration's bill.

Senator DANFORTH. The 9 percent?

Mr. WISNIEWSKI. Yes.

Senator DANFORTH. You would view that as temporary?

Mr. WISNIEWSKI. Yes. We would view that as temporary, until the health security system would be in place.

Senator DANFORTH. What do you mean by the health security system?

Mr. WISNIEWSKI. National health insurance.

Senator DANFORTH. Would national health insurance be simply a way of paying the costs or a way of limiting the costs?

Mr. WISNIEWSKI. We feel that there are adequate safeguards in the program through its budgeting mechanisms to hold down the rise in healthcare costs and limit them to reasonable levels.

Senator DANFORTH. Thank you.

Senator TALMADGE. S. 1391, I believe, is the number of the administration bill and it has a cap on virtually everything but wages.

Mr. WISNIEWSKI. That is correct, in part. The so-called wage pass-through is not, in essence, a passthrough; simply optional as far as the hospital is concerned. The hospital can decide whether or not to pass-through wages.

Senator TALMADGE. Thank you very much, gentlemen, for your contribution to our deliberations.

[The prepared statement of Mr. Wisniewski follows:]

STATEMENT OF STANLEY WISNIEWSKI, RESEARCH DIRECTOR SERVICE EMPLOYEES
INTERNATIONAL UNION, AFL-CIO

I am Stanley Wisniewski, Research Director for the Service Employees International Union. We represent 600,000 workers in private industry and the public sector, including over 200,000 healthcare workers.

All of the workers we represent are seriously affected by the problem of healthcare inflation. Many of our members are low-wage service workers, and consequently find it difficult to deal with the high cost of medical care. Ironically, among the workers hardest hit by medical care inflation are healthcare service workers whose wages still remain below the level of earnings enjoyed by workers in most other sectors of the economy.

The average non-supervisory hospital worker earned \$4.18 an hour in 1976—a rate lower than the average wage earned in the service sector, in manufacturing, or in the private economy taken as a whole (as illustrated in the appended Table I). Most health-care workers—nurses, nurses' aides and service workers—are inadequately paid and find it difficult to shoulder the burden of rising healthcare costs. Based on a forty-hour week, the average nonsupervisory worker's annual salary in 1976 would have approximated \$8,694. By comparison, in Autumn 1976, the U.S. average cost of the lower budget for an urban family of four was \$10,041 a year, while the intermediate and higher levels were \$16,236 and \$23,759 respectively.

As a result of the inadequate wages received by healthcare workers, the gap between their earnings and the price of medical care has widened over the years. During the past ten years, hospital room rates have risen nearly twice as fast as hourly wages. Therefore, we welcome initiatives aimed at moderating the rise in healthcare costs but we are strongly opposed to any program that would interfere with free collective bargaining in the hospital industry or hold down the wages of hospital workers. We believe that to be effective, a healthcare cost containment proposal must address the real causes of inflation—mismanagement, poor planning, and wasteful duplication of services—rather than impose additional hardships on already poorly compensated wage earners.

Hospital workers are the victims, not the cause, of medical care inflation. The rapid increases in the cost of medical care are not attributable to non-supervisory labor costs. Over the past fifteen years, less and less of the hospital dollar was spent on labor costs each year. This trend is remarkable in view of the ever-rising demand for more and better skilled healthcare workers through-

out the period. The number of healthcare workers employed in hospitals increased from 1,763,000 in 1962 to 3,023,000 in 1975 and the number of workers per 100 census (average daily hospital census) more than doubled to 269 employees per 100 census. In addition, the types of healthcare workers and the skills they possess have been dramatically upgraded with the introduction of new paraprofessional and technical positions. Yet, notwithstanding these huge increments in both the quantity and quality of hospital manpower, payroll expenses have steadily declined as a proportion of total hospital expenses from 66.5 percent in 1962 to 51.1 percent in the last quarter of 1976.

Total labor costs in the hospital industry now account for a little more than half of operating costs and the salaries of administrative and supervisory personnel account for roughly one-third of these labor costs. In other words, non-supervisory and non-administrative labor costs currently absorb approximately 35 percent of total operating costs.

The available evidence clearly demonstrates that nonsupervisory labor costs, whether union or non-union, had little to do with inflation in healthcare prices. For example, the Council on Wage and Price Stability recently released a study which estimates that limiting the rise in the rate of earnings increase of hospital employees to the increases experienced by all private nonfarm production workers over the 1955-75 period would have only reduced the annual rate of increase in average cost per patient day from 9.9 percent to 8.8 percent.¹ In other words, total labor costs were the source of only about one-tenth of the annual increase in hospital costs.

Other recent studies of hospital worker wages which focus on only collectively bargained wages indicate that the union impact on hospital costs appear to be in the range of 1-2 percent.² Moreover, while unionized hospitals pay higher wages they may experience lower labor costs because, unlike their nonunion counterparts, they are troubled less by high labor turnover rates.

With about 18 to 20 percent of all hospital workers organized and with total payroll costs representing roughly 51 percent of operating costs, organized labor accounts for only 10 percent of hospital costs. Clearly, this is too small a portion to have had a significant impact on health-care inflation.

Collectively bargained wage increases in the healthcare industry have not been excessive as indicated by the data provided in the appended Table II. The average increase³ which became effective during 1975, in SEIU contracts was 7.8 percent, while for 1976, the average increase was 7.1 percent. To date, in 1977, those increases which have occurred or are expected to occur on the basis of previously negotiated settlements average 7.1 percent. These increases can hardly be termed excessive inasmuch as the effective wage rate changes reported by the Bureau of Labor Statistics for wage settlements in the private sector as a whole averaged 8.7 percent in 1975 and 8.1 percent in 1976.

Clearly, labor costs have played a minor role in pushing hospital costs upward. Healthcare workers are the victims of rising health costs as much as anyone else, or perhaps even more so, since they are less able to afford such price increases. Workers engaged in manufacturing earn at least a full dollar more than the average hospital worker. In actual dollars and cents, hospital workers gained only \$1.39 in increased hourly wages since 1970, while the average worker in the private sector increased his earning by \$1.65. Therefore, we find S. 1470 highly objectionable because it unfairly places the burden of controlling hospital costs on the shoulders of low-wage hospital workers.

Section 2(b) (aa) (3) (E) of the proposed legislation erroneously tries to set hospital wages on the basis of comparisons with their counterparts outside hospitals in the same geographic area, when in fact, in most instances, comparable occupations either do not exist outside hospitals or else, do not exist in sufficient numbers to permit meaningful comparisons. Occupations which make up the bulk (80-85 percent) of the nonsupervisory hospital workforce such as nurses aides, psychiatric aides, licensed practical nurses, medical records technicians, medical technologists, respiratory therapists, radiologic technologists, admitting clerks and registered nurses are not found employed outside the healthcare industry in significant numbers and, even where they do exist, their

¹ Martin Feldstein and Amy Taylor, *The Rapid Rise of Hospital Costs: A Staff Report of the President's Council on Wage and Price Stability*, January, 1977, p. 17.

² Myron D. Fottler, "The Union Impact on Hospital Wages," *Industrial and Labor Relations Review*, Vol. 30, No. 3, p. 354.

³ A weighted average increase including both first year adjustments and adjustments resulting from prior settlements.

job responsibilities are often vastly different. Even in those few instances where comparisons between hospital and general wage levels for a particular occupation can be made, methodological problems such as obtaining data outside major metropolitan areas, timing the collection and analysis of the data to meet the needs of the legislation, collecting accurate fringe benefit data on an annual basis would prove to be a formidable and expensive task for the government's statistical agencies.

Section 2(b)(aa)(3)(E) of S. 1470 makes no effort to separate wage and salary data for supervisory and administrative personnel from data for non-supervisory personnel. The net result of this omission is that low-paid nonsupervisory personnel can have their wage increases restricted because they happen to work at a hospital with highly paid administrative personnel.

Section 2(b)(aa)(3)(E) also makes no distinction as to the size of the hospital in making its comparisons. Irrespective of the size or nature of the hospital, occupations are to be compared to the same general area wage levels—completely ignoring the different labor market factors that may impact on each situation.

Notwithstanding all these shortcomings in its proposed mechanism for setting a limit on hospital personnel costs, S. 1470 not only attempts to control wage increases but, after, 1979, could form the basis for wage cuts. It is unconscionable to contemplate wage cuts in an industry in which the average nonsupervisory wage already lags behind wages in practically every other major industry and where low-paid workers are hard-pressed to deal with pains of the general rate of inflation.

Furthermore, Section 2(b)(aa)(3)(E) provides hospitals with an incentive to continue to increase expenditures in those areas which have been most responsible for health care inflation at the expense of low-paid workers. This terrible state of affairs is precipitated whenever the hospital wage level is below the permissible limit, because irrespective of its actual expenditures for wages the hospital is reimbursed the full permissible limit to the extent that they can lower wages below the amount allocated to them by the personnel cost formula. In short, a hospital is able to shift the burden of the program onto the low-wage workers through a refusal to grant any wage increase.

In view of the fact that wage increases for hospital workers have not been responsible for the rapid rise in hospital costs and that nonsupervisory workers are still severely underpaid, we believe that the system of wage controls advocated in S. 1470 is unjustified, unfair and unworkable. Moreover, it represents an unwarranted interference with the rights of hospital workers to engage in free collective bargaining—a right which was finally extended to all private sector hospital workers in the 1974 amendments to the National Labor Relations Act. Therefore, we are adamantly opposed to S. 1470 as proposed. We believe that the wages of these nonsupervisory workers should rightfully be excluded from the scope of this legislation.

As consumers of medical care we appreciate S. 1470's efforts towards establishing a uniform accounting and reporting system, however, at the same time we are dismayed by Section 44 which would prohibit the release of the names of physicians who have been paid large amounts for treating Medicare patients. It is the lack of information available on provider activities in the industry that encourages abuse. We favor full financial disclosure for all providers in the health care industry.

On behalf of the members of the Service Employees International Union, I thank the Committee for the opportunity to present our views.

TABLE I.—AVERAGE HOURLY EARNINGS (NONSUPERVISORY EMPLOYEES)

	Total private	Service	Hospitals
1968.....	\$2.85	\$2.43	\$2.31
1969.....	3.04	2.61	2.57
1970.....	3.22	2.81	2.79
1971.....	3.43	3.01	2.96
1972.....	3.65	3.40	3.08
1973.....	3.92	3.46	3.22
1974.....	4.22	3.76	3.45
1975.....	4.54	4.06	3.83
1976.....	4.87	4.36	4.18
Dollar increase 1968-76.....	2.02	1.93	1.87

TABLE II.—SEIU COLLECTIVELY BARGAINED HOSPITAL AGREEMENTS

State and increase dates	Unit percent increase	Percent increase, selected occupations					Other
		Nurse's aide	Maid	Porter	LPN	Regis- tered nurses	
California—14,900 employees (more than 26 hospitals):							
1976	8.2	8.5	¹ 8.7		8.1		
1977	7.2	7.2	¹ 7.4		7.1		
1978	6.8	7.4	¹ 7.6		7.0		
Colorado—272 employees (1 hospital):							
1975	11.0	² 11.0			11.0		
1976	12.0	² 12.0			12.0		
1977	6.5	² 6.5			6.5		
1978	6.0	² 6.0			6.0		
District of Columbia—1,700 employees (1 hospital):							
1975	9.7	11.0	11.0		9.2		
1976	6.3	7.1	7.2		6.0		
1977	7.1	7.3	8.0		6.8		
Illinois—4,021 employees (3 hospitals):							
1975	7.4	7.1	6.8				
1976	7.9	8.0	7.3				
1977	6.2	5.8	7.9				
Massachusetts—330 employees (1 hospital): 1976	8.0	8.0	8.0	8.0	8.0		
Michigan—2,327 employees (6 hospitals):							
1975	8.2	8.1	³ 7.7		10.1		
1976	6.4	7.1	³ 7.1		6.3	7.8	⁴ 5.6
1977	5.9	6.5	³ 6.5		5.4		⁴ 2.1
1978	4.4	4.6			4.5		
Minnesota—5,000 employees (20 hospitals): 1976	5.0	5.3	³ 5.3				
Missouri—500 employees (1 hospital):							
1976	10.6	11.4	³ 11.4				
1977	9.6	10.2	³ 10.2				
New York—6,000 employees (14 hospitals): 1976	5.0	5.0	5.0	5.0	5.0		
Ohio—2,391 employees (4 hospitals):							
1975	6.4	6.6	6.9	6.5			
1976	6.6	7.5	7.9	6.8			
1977	7.1	8.2	8.7	⁵ 8.2			
1978	7.0	⁵ 7.2	⁵ 7.8	⁵ 7.6			
Oregon—980 employees (4 hospitals):							
1975	⁵ 8.0	8.6	⁶ 8.5		8.0		
1976	7.3	7.3	⁶ 7.7		7.7		⁷ 9.0
1977	7.1	7.0	⁶ 7.0		7.4		⁷ 7.1
1978	6.7	7.0	⁶ 6.7		7.0		⁷ 6.8
Pennsylvania—650 employees (5 hospitals)							
1976	11.3	11.0	⁶ 12.4		9.8		
1977	8.8	10.0	⁶ 7.6		9.6		
1978	10.4	13.1	⁶ 8.7		11.4		
Washington—760 employees (3 hospitals):							
1975	8.0	9.2	⁶ 9.2				
1976	8.2	9.7	⁶ 9.3		9.5		
1977	7.5	7.2	⁶ 7.3		7.6		
Total SEIU weighted average:							
1975	7.8						
1976	7.1						
1977	7.1						

¹ Hospital aide.² Clinic aide.³ Maid/porters.⁴ Medical technicians.⁵ 1 hospital.⁶ Housekeepers.⁷ Clericals.

Senator TALMADGE. The next witness is Morton D. Miller, vice chairman, Equitable Life Assurance Society of the United States, accompanied by William C. White, Jr., vice president, Prudential Insurance Company of America on behalf of the Health Insurance Association of America.

You may insert your full statement in the record and summarize it in 10 minutes, if you will, please.

STATEMENT OF MORTON D. MILLER, VICE CHAIRMAN, EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES; ACCOMPANIED BY WILLIAM C. WHITE, JR., VICE PRESIDENT, PRUDENTIAL INSURANCE CO. OF AMERICA, ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. MILLER. My name is Morton D. Miller. I am vice chairman of the Board of Directors of the Equitable Life Assurance Society of the United States. With me are Mr. William C. White, Jr., vice president, Governmental Health Programs Office of the Prudential Insurance Co. of America, and Mr. Louis A. Orsini, vice president and director of the Consumer and Professional Relations Division of the Health Insurance Association of America. We appear today on behalf of the Health Insurance Association of America.

The companies we represent, which provide health insurance protection for over 100 million Americans, have long been intimately concerned with the costs of health care in this country. In that connection, we have lent our active support to community health planning, increased ambulatory care, alternative delivery systems, health education, professional standards review, and a better distribution of health manpower.

S. 1470 contains many progressive concepts which merit discussion, such as payment for the costs incurred in closing underutilized facilities or converting them to other uses. However, because of time limitations, our testimony will be confined to a discussion of the hospital reimbursement reforms proposed in section 2 of the bill. We have filed an extended written statement that includes supporting material for these comments, as well as observations on the other sections of the bill.

The rapid escalation of costs during the last several years which has spread across the full spectrum of health services—with particular impact on the costs of hospital care—has created a most worrisome situation.

The problem is a serious one that calls for remedial legislation. The drafters of S. 1470 are to be complimented for their initiative in addressing the problem and in formulating a legislative solution.

Mr. Chairman, we are familiar with the complicated web of interrelated causes which have brought about the health care cost escalation we have been experiencing. One of the contributing factors has been the growth of third party payment for health care services, both private and public, to the point where third party financing represents over 90 percent of total hospital revenues. Because of our success in extending coverage for health care expenses to so many people, the normal economic forces of the marketplace do not operate. By and large, the American public has been so shielded from the direct impact of health care costs that there is an almost limitless demand for health care services. This is matched by the providers' readiness to increase the supply of services, secure in the knowledge that under present reimbursement systems costs incurred will generally be recouped. Thus, both supply and demand tend to accelerate unchecked.

We fully support the objectives of section 2 of S. 1740 to contain the rising costs of hospital care. However, the cost escalation does not affect the medicare and medicaid programs alone but extends to the entire health care financing system and all of the American people. We feel that section 2 should be strengthened so as to afford protection for all Americans. We applaud the fact that this legislation, and the chairman's introductory remarks, acknowledge the need for controlling total hospital revenues and indicate that the system of permanent controls could be broadened to include all third party payors, public and private, if a consensus favored this approach. We would like to be counted as part of that consensus.

The National Health Care Act (S. 5, H.R. 5), introduced by Senator McIntyre and Representative Burleson and supported by the health insurance companies of America, includes a plan for hospital cost containment upon which we believe such a consensus can be built.

First, hospital cost containment must apply to total revenues to be effective. Reimbursement controls, which are based on per diem costs, provide no incentive for hospitals to reduce the total number of inpatient days. On the contrary despite the influence of professional standards review organizations, which now encompass only medicare and medicaid patients, institutions would be free to extend the length of stay in order to offset savings resulting from the limit on the per diem charges. The motivation to do so would be strong because the costs incurred per day of care decrease sharply after the first few days of confinement.

Second, we seriously question the efficacy of a system which deals only with inpatient care. Under such a system, hospitals could achieve their revenue objectives by manipulating the allocation of expenses to outpatient costs and to those inpatient costs not included in "routine operating costs," particularly ancillary services.

Finally, the focus of S. 1470 on cost containment measures for medicare and medicaid patients alone is a serious weakness. True, the possibility of expenses not reimbursed by the Government programs being shifted to other third-party payors and self-pay patients has been recognized in S. 1470. However, the provision of the bill which would require hospitals to agree not to offset reductions in medicare and medicaid payments by increasing the charges to other patients would be extremely difficult to monitor and enforce. The desired result can be achieved by basing reimbursement controls on total revenues received from all payors.

I would now like to touch on the highlights of our suggestions for strengthening the hospital cost control provisions of S. 1470. First, S. 1470 should be amended to establish a Federal system for limiting increases in total revenues hospital by hospital.

Second, the bill should provide that hospitals in those States which institute prospective budget review and rate approval programs that meet Federal guidelines should be exempted from the Federal system. We favor inclusion of strong incentives for States to set up such systems because we believe budget and rate review are essential elements in effective health planning and utilization review, which activity should be extended to encompass all patients. Since health planning and utilization review both operate at the State level, improved co-

ordination and mutual strengthening would result from having budget review and rate approval operate at the State level also. For administration of State systems of prospective budget review and rate approval, Federal guidelines should incorporate the following principles;

(a) Efficient prospective budget review and rate approval methodology encompassing revenue from all payors and applicable to all institutions should be set forth;

(b) Optimal use of health resources should be sought by requiring coordination of budget review and rate approval with health planning and utilization review;

(c) Improved institutional management, budgeting and efficiency should be encouraged;

(d) Incentives to contain the rate of increase in cost should not impair the quality of care;

(e) Rates for services should be set equitably for all purchasers of care;

(f) A hospital's total costs should be reasonably related to the efficient provision of services;

(g) Aggregate revenues should be reasonable in relation to aggregate costs; and

(h) Rates for individual services should be reasonably related to the costs of providing the services.

These proposed Federal guidelines incorporated the best features of the two successful programs now in operation in Connecticut and Maryland, and seek to correct weaknesses in those efforts.

In Maryland and Connecticut, the State rate setting commissions have saved residents \$27 and \$18 million a year, respectively. To illustrate the potential of extending this type of program nationwide, we estimate there would have been savings in the order of \$1 billion last year.

In summary, we feel that the concepts and objectives of S. 1470 are excellent, and that the bill is clearly moving in the right direction. The importance of this legislation to the over 100 million people to whom our member companies provide health insurance protection and indeed to all Americans cannot be overemphasized. We and the staff of the Health Insurance Association of America would be pleased to assist the committee and its staff in helping to perfect the amendatory provisions to the bill we have suggested and in any other appropriate way.

Thank you, Mr. Chairman.

Senator TALMADGE. Thank you, Mr. Miller, for your very helpful and constructive suggestions. We would appreciate your continuing to work with the staff.

Senator Danforth?

Senator DANFORTH. Under the present system there is no disincentive to overutilization. That is your position?

Mr. MILLER. There is to the extent that the PSRO organizations are functioning. One of their purposes was to review utilization as well as quality, and the PSRO organizations are working in some areas. They are not, by any means, nationwide in their operations to this point. The previous witness referred to the point that one of the

reasons was inadequate funding by the Federal Government to get these organizations going so they have not yet been tested.

It is my impression in the areas that they have begun to operate, some initial favorable results have been in evidence.

Senator DANFORTH. When Secretary Califano testified, he stated that the greatest problem was the reimbursement.

Mr. MILLER. It is a significant problem and we recognize that. As I have suggested here both through public programs, medicaid and medicare and the vast number of private programs, we have taken over the paying for so much medical care the individual no longer has a substantial economic incentive in many instances, to say he will choose to seek a service or not to seek a service, or whether he will seek to stay on in a hospital longer than necessary if he can.

That is something that is of deep concern to all of us.

One of the things that we think might well go a significant way toward attacking this problem is getting individuals, you and I and our families, to realize that there is a great deal that we can do. Not only to understand the impact the cost increases are having on each and all of us, but also that the way we live, our style of life, can go a long way toward avoiding the need for medical care.

Many examples are obvious to me. If we drive a little less fast. If we do not smoke so much. If we do not eat so much and to become obese. If we otherwise attempt to regulate our lives in a more sensible way. I get a sense of a significant thrust beginning to develop in the area of health education in the broadest sense, both as to the use of medical care and hospital care facilities and also in the style of life, how we live ourselves, is gaining momentum. There is a National Center for Health Education that was set up about 2 years ago, and it is beginning to make itself known and accepted. We see in industry and among individuals a lot of indication that this sort of thing is catching on. From the point of view of industry, perhaps it is in part selfish since industry pays a good part of the premiums which we collect in order to provide protection, are seeing those costs rise. They want to try to counter them and feel this is one way to do so.

On the other hand, there are a number of evidences that self-care by individuals is growing even apart from that. One example, of course, is this testing for breast cancer that has been recommended to women so extensively and has caught hold and is being affected.

Senator DANFORTH. I do not want to cut you short, but Secretary Califano took the position that the nub of the problem is the system of reimbursement which we now have. As I understand the point he was making, where you have a situation in which reimbursement is on a cost-plus kind of basis, there is no disincentive for overutilization. When you have an unlimited amount of money going into a relatively closed system, the costs will increase.

I gather from the thrust of your comments and your concentration this morning that this is practically the same position that you would take?

Mr. MILLER. It is.

One cannot say that it is not a major factor. We have tried to counteract it in many ways. We have encouraged employers and others

who develop insurance plans for their employees to do several things: put more emphasis on the reimbursement of ambulatory care services as against hospital care services, which heretofore had not been the case. Historically, the development of insurance in this country focused initially and continued to have a very heavy emphasis on the in-hospital costs.

We now realize in retrospect, that was the wrong thing to do. What we are trying to do now is encourage the development of plans that at least more equally treat ambulatory care reimbursement as against hospital care reimbursement so as to reduce the need to go into the hospital.

We are also trying to encourage the people that we insure to revise their plans, insofar as they can, to give the individual something more of a financial incentive to be concerned with the services provided. Not one that would bankrupt him or have a serious impact on his financial situation, but one that would give him some incentive to see what was happening to him and whether he should seek such a service or not.

Senator DANFORTH. Thank you.

Senator TALMADGE. Thank you very much, gentlemen.

Mr. MILLER. Thank you very much, sir.

[Further comments of Mr. Miller follow:]

FURTHER COMMENTS BY MR. MORTON D. MILLER ON S. 1470

SECTION 2—CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

We agree with Senator Talmadge that the hospital cost containment initiatives contained in Section 2 of S. 1470 would be strengthened if they were to encompass all patients. The experience to date in those states which apply prospective budget review and rate approval systems to all patients, leads us to believe that Federal incentives for the extension of such systems to other states should be enacted.

One incentive would be for states to be exempt from the provisions of other Federal hospital cost containment programs, such as a national system for limiting increases on total revenues, if their state program met certain Federal guidelines.

Based upon our experience we believe such guidelines include consideration of the following:

1. In order to maximize the effectiveness of the program it must include all hospitals in the state and the care rendered to all patients; both the beneficiaries of governmental and private sector financed programs.

2. Each state should establish either a full-time commission appointed by the Governor or a rate-setting agency under the direction of a single full-time commissioner. A state commission should be appointed by the Governor for staggered terms of no less than four years. Members of the commission should have a basic understanding of the delivery and financing of health services in the state. They should not, during their term of office, be otherwise employed by the state, employees or officials of a local government or a health care institution, nor should they engage in the delivery and/or financing of health services in the state.

3. A representative policy board made up of one-third providers, one-third consumers, and one-third purchasers of health care should be appointed by the Governor for staggered terms. The objective of the policy board is to establish a check against domination of the commission's activities by the commissioners, the commission staff, the Governor, or any other particular interest group while also providing a meaningful resource for the work of the commission.

The policy board should be authorized to—

- (a) Review and comment on regulations for approval of hospital rates and budgets;

(b) Review and comment on rules and regulations regarding uniform accounting and reporting;

(c) Review and recommend approval or disapproval of the commission's annual budget;

(d) Provide advice on the integration of state rate approval with certificate-of-need, utilization review, and other state regulatory functions;

(e) Report to the commission, Governor, the state legislature and other appropriate agencies of the state on the program's effectiveness, recommended modifications and continuation; and

(f) Review and recommend approval or disapproval of the regulations under which the commission itself functions.

4. The commission should be charged with the coordination of need law and the review of all operations of institutional services, including operating and capital budgets and gross operating revenues on an annual basis. If the administration of the certificate-of-need and budget review programs are located in different state agencies there should be close coordination between the programs in order for them to be effective.

The evaluation of the financial impact of proposed new facilities and services by the rate review authority must be considered in the certification of need process. The effectiveness of any certification of need agency in allocating new capital expenditures or promoting relocation, merger and closure of facilities and services will depend in great part on fiscal sanctions of the budget review mechanism. Therefore, in evaluating increased capital expenditures, the commission should approve costs only for those facilities and services which have been approved by the appropriate planning agency.

5. In order for the commission staff to appropriately analyze hospital budgets and rate requests on a comparable year-to-year and hospital-to-hospital basis, it is necessary to establish a system of uniform financial recordkeeping. Institutions should be required to follow the uniform system of cost and revenue accounting developed under Section 1533(d) of P.L. 93-641 or Section 2(aa) (A) of S. 1470 or any other system reviewed by the policy board and used as the basis for the commission's budget review and approval process.

6. There should be a uniform definition of "Full Financial Requirements" which will be the basis for equal payment for equal services by all patients. "Full Financial Requirements" includes the cost of unreimbursed care for the indigent and bad debts on both an in-patient and out-patient basis.

Because of the wide discrepancy between the amount paid by many state Medicaid programs and the private sector patient for the same services, the state implementing legislation should permit it to avail itself of the same maximum allowable increase limitation which the Federal government is allowed for its costs under Medicare and Medicaid. Thus, the state (as well as the Federal government under Title XVIII and its participation under Title XIX) would be required to fund its share of Medicaid payments based on the rates approved by the program either under Federal or state agency administration subject to a maximum allowable increase. Any excess would be charged to all non-governmental patients by means of a surcharge on the approved rates for the following year.

Because of the assured financing, both short and long range, this definition would enable the hospital to increase the availability of out-patient services to the indigent and medically indigent population, particularly in the inner cities where care is now needed.

7. In the evaluation of increased operating cost, the commission's guidelines should define both comparative and normative standards of reasonableness to which the institution should adhere in supporting increases.

8. In supporting cost increase due to volume changes, e.g., utilization or intensity of services, the guidelines should require the institution to file with the state rate setting agency a quality assurance plan for all patients which provides for routine monitoring of appropriateness of the confinement, and the duration, and the quality of care rendered. By extending the PSRO program to all patients this requirement would be satisfied.

In addition, the system should clearly identify additional revenues generated by increased volume and establish a methodology for separating fixed and variable costs associated with such service volumes. The amount of reimbursement for the fixed cost component associated with the additional revenues should be used to reduce the hospital's financial requirements for the following year.

9. The guidelines should give the state agency the option of either requiring each institution to submit its budget and rates annually for review and approval or establishing a quadrennial review of all institutions with a special review of institutions who request increases in excess of a predetermined limit in a given year. Review of rates alone does not provide an opportunity to review hospital costs during the hospital's budgeting process. The state agency must also have the authority to reconcile a hospital's budgeted costs, revenues and volume of services with actual experience.

10. The guidelines should permit an institution to petition the state agency for an emergency rate increase during the period between budget reviews where it can show costs have been inflated due to factors beyond the institution's control (e.g., reduction in expected occupancy levels, malpractice insurance, fuel costs, etc.). Once an institution has submitted its budget to review and received approval, it should be encouraged to generate surpluses due to improved efficiency or productivity. The surpluses so earned should be disposed of on a basis consistent with management prerogatives. Expenditures of such surpluses should be accounted for in subsequent accounting periods and should not call into question the tax exempt status of hospitals.

11. There should be an appropriate administrative and judicial appeals process; and finally

12. The legislation may make provision for a differential where the action of the patient, or a prepayment plan or insurance company on the patient's behalf, results in demonstrable savings to the institution; e.g., a patient paying the full bill at discharge reduces the hospital's normal credit collection and operating costs. The criteria for the differential should be established by the state agency, depending on the circumstances involved, and should be available without regard to third party sponsorship or lack thereof.

FINANCING

S. 1470 should be amended to provide one-time development grants to assist states in establishing budget review and approval agencies. Such grants should be on a graduated per capita scale, e.g., 70 cents for each of the first 500,000 of the state's population; 50 cents for the second 500,000; 30 cents for the third 50,000; and 10 cents for each of the balance of the state's population with a minimum grant per state of \$500,000.

The continuing operating costs of the agency could be financed by an assessment against the health care institutions in the state.

FEDERAL ADVISORY COUNCIL ON HOSPITAL COST CONTAINMENT

We also propose that S. 1470 be amended to create an advisory council to assist the Executive Branch and Congress in evaluating the experience under competing reimbursement systems and make recommendations for improvement in cost containment programs as that experience develops.

A council with balanced representation of providers, third-party purchasers and consumers active in the planning process, would be responsible for monitoring the ongoing operation of the program and would make an annual report to the Secretary of DHEW and the appropriate congressional committees on the program's effectiveness including recommendations for modification of the program.

The report should:

1. Measure the effectiveness of the programs in reducing hospital cost increases and identify the factors which have caused the reduction.

2. Assess the program's impact on improved efficiency in determining the quality of institutional health care services, the utilization of such services, and support for the planning process.

SECTION 3—PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

We support this provision with one amendment. In light of our proposal that revenue limits apply to all sources of payment for hospital services, capital costs associated with a qualified conversion or closing should be allowable items of cost with respect to *all* sources of reimbursement. That is, transitional allowances should not be limited to reasonable costs determined under Titles V, XVIII and XIX of the Social Security Act.

SECTION 4—FEDERAL PARTICIPATION IN HOSPITAL CAPITAL EXPENDITURES

We support the linkage of the capital expenditure review procedure for Medicare and Medicaid reimbursement to the health planning structure created by P.L. 93-641, The National Health Planning and Resources Development Act of 1974. We are concerned about the provision granting the Secretary of DHEW authority to include, as an allowable item of reimbursement, costs associated with unapproved capital expenditures under certain circumstances. We feel that proper review and appeal procedures established by P.L. 93-641 are a preferable solution.

SECTION 10—AGREEMENT BY PHYSICIANS TO ACCEPT ASSIGNMENTS

The concept of "participating" and "nonparticipating" physicians seems logical on the surface. The proposed simplified billing form could be an administrative monstrosity if all other requirements under existing rules and regulations must be met.

An alternative approach which might have more appeal to the physicians would be to provide that reasonable charge determinations for participating physicians be based on the 90th percentile rather than the 75th percentile. To improve administrative procedures, it might be required that participating physicians code all claims. We recommend that a participating physician agreement may be terminated only upon 90 days' notice to the Secretary in order to provide sufficient time for the carrier to make the necessary administrative changes in its participating physician profile.

SECTION 11—CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

We agree with the provision in this section for the improvement of the reimbursement to physicians in physician shortage areas, but we do have some concern about other provisions of this section.

The application of a new limit on locality prevailing charges in addition to the limit established by the economic index factor may further discourage the acceptance of assignments by physicians. We do not have a statistical evaluation of the impact of this proposal as set forth in this section of the bill. While it is understandable that the Federal Government wishes to control increases in benefit payments, the impact on beneficiaries should be considered. If the proposed approach does, in fact, further limit annual increases in prevailing charges, with further decreases in the assignment rates, the elderly beneficiary will be hit even harder than he now is for out-of-pocket expenses. Because of the unknown degree of impact, perhaps this proposal should be deferred. Alternative methods of determining benefits payments under Medicare should be investigated to arrive at the best possible solution from the beneficiary's standpoint.

We recommend that existing law be changed to provide for the updating of physician profiles and prevailing charges on a semi-annual basis. The current system of annual updating on July 1 of each year based on charges rendered during the prior calendar year produces an excessive time lag. This is a disincentive to the physician in his consideration of whether to accept assignment of benefits.

SECTION 12—HOSPITAL ASSOCIATED PHYSICIANS

We noted with approval that this section now applies to both Medicare and Medical and encompasses all hospital-based physicians.

We are in agreement with the need for further control and, from a conceptual viewpoint, the provisions address themselves to real problems. We repeat our recommendation that consideration should be given to providing that reimbursement to all hospital-based physicians be made on the basis of reasonable cost to the hospital with payments to the hospital under Part A of Medicare.

SECTION 13—PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF MEDICARE

We support this provision.

SECTION 14—PAYMENT ON BEHALF OF DECEASED INDIVIDUALS

We completely endorse this proposed change.

SECTION 15—USE OF APPROVED RELATIVE VALUE SCHEDULES

Recent consent decrees secured by the Federal Trade Commission pertaining to the use of relative value schedules by several professional societies have caused confusion as to the legality of the usage of such schedules. They are, however, an essential element in claim processing and clarification permitting usage, as outlined in this provision, is most welcome. We share the goal of achieving uniform coding and terminology, but suggest carriers be given sufficient leeway to add, delete or modify such coding and terminology, as required by administrative agencies.

Section 20—No comment.
 Section 21—No comment.
 Section 22—No comment.
 Section 23—No comment.
 Section 30—No comment.

SECTION 31—STATE MEDICAID ADMINISTRATION

While we agree with the intent of this provision, we are concerned about the possible adverse impact of the penalties proposed. If a state fails to meet any one of four criteria for administration, as set forth in the bill, and does not correct such deficiency within six months, 50% of the Federal matching funds for administration would be terminated. Failure to meet any two criteria, without corrective action within six months, calls for complete termination of Federal matching funds.

If there are serious deficiencies, a six-month period for corrective action would appear to be too short. Also, reduction or termination of Federal matching funds for administration may cause further deterioration in the state's administrative procedures resulting in massive overpayments of Medicaid benefits, including Federal matching funds, which could far exceed the administrative expenses.

Rather than to impose penalties which could be counterproductive, the Federal Government should provide technical assistance to the states, as proposed in the bill, with increased Federal matching funds for administrative expenses for those states meeting or exceeding established criteria. The resulting improvement in administrative procedures could provide substantial savings in benefit payments far exceeding the additional cost to the Federal Government for the increased amount of matching funds for administration.

SECTION 32—REGULATIONS OF THE SECRETARY

We favor this proposal.

SECTION 33—REPEAL OF SECTION 1867

Perhaps consideration should be given to a restructuring of this council in order to provide input to the Secretary of Health, Education and Welfare with respect to the problems of Medicare and Medicaid and other government health programs from interested and knowledgeable public representatives.

Section 40—No comment.

SECTION 41—AMBULANCE SERVICE

We agree with the provision.

Section 42—No comment.

Section 43—No comment.

SECTION 44—DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

Routine disclosure of such information serves no useful purpose. Therefore, we wholeheartedly endorse this proposal.

SECTION 45—RESOURCES OF MEDICAID APPLICANT TO INCLUDE PROPERTY DISPOSED OF TO APPLICANT'S RELATIVE

This provision is applicable only if the disposition of assets is made to a relative. Such a restriction nullifies the effect of the provision and does not close the loophole. Consideration should be given to extending it to *any* situation in which an applicant for Medicaid benefits has intentionally disposed of assets at less than fair market values.

SECTION 46—RATE OF RETURN ON NET EQUITY FOR-PROFIT HOSPITALS

We support this provision.

Senator TALMADGE. The next witness is Mr. Tom E. Greene III, vice president, Paine, Webber, Jackson & Curtis, Inc. on behalf of the hospital financing study group.

Mr. Greene happens to be a former citizen of Georgia and an old family friend of mine. It is a pleasure to welcome you before our committee, sir.

Mr. GREENE. Thank you for that introduction, Senator.

STATEMENT OF TOM E. GREENE III, VICE PRESIDENT, PAINE, WEBBER, JACKSON & CURTIS, INC., ON BEHALF OF HOSPITAL FINANCING STUDY GROUP

Mr. Chairman and members of the subcommittee, my name is Tom Greene and I am here to speak in support of S. 1470. I represent the hospital financing study group, an informal association of the public finance departments of most of the investment banking firms in this country which do health care capital financing. Our membership includes such well-known names as Merrill Lynch, Pierce, Fenner & Smith and E. F. Hutton. I, myself, am vice president for public finance at Paine, Webber, Jackson & Curtis, another HFSG member. I am delighted to have this opportunity to express the fundamental support of the financial community for the bill which you are presently considering.

The hospital financing study group approaches S. 1470 from a perspective which differs from that of most of the witnesses who have or will testify on the bill before you. We do not deliver health care; we deliver money. Our expertise is in the area of raising capital which is needed to renovate and modernize hospitals. Our experience in raising private sector money to pay for hospital capital expenditures leads us to two straightforward propositions: first, there is fat which can be pruned from the national hospital capital budget; second, Congress should avoid taking any steps which will raise the cost of hospital capital. Let me explain both of these points.

First, there are excesses in the national hospital capital budget. This point is well documented. Consider, for example, the report entitled "Reducing Excess Hospital Capacity," released by HEW just 2 months ago. According to this report, we could achieve a 10-percent reduction in our hospital bed capacity simply by eliminating beds which are either not used or are inefficiently used.

If we want to go even further and attack what many regard as widespread overuse of hospital beds, then even greater reductions in capacity are possible.

Section 3 of your bill is particularly appropriate in view of this problem of overbedding in that it would cover some of the reimbursement detriment which a hospital would otherwise suffer when retiring unneeded beds.

The problem of excess capital expenditures in health care is not just a matter of too many beds. It is also a problem of capital projects which are, themselves, necessary but which are unnecessarily expensive. Let me give you an example of a capital project where careful,

cost-conscious planning significantly reduced the overall price tag. My firm became involved in financing the complete replacement of a 116-bed nonconforming hospital. As originally proposed, the construction cost for the new hospital was \$7 million, requiring a total bond issue of \$7 million. Our initial conclusion was that the project as proposed was not financially feasible. The projected debt service obligations simply would be too large to be carried by the hospital's stream of revenues. Therefore, we recommend to the hospital several ways of reducing the size of the borrowing to manageable proportions.

Basically, we proposed that the hospital's debt service obligation be reduced by paring down the construction costs of the replacement facility. We felt that the overall size of the new facility could be reduced by redesigning the building from 130,000 square feet to 100,000 square feet without lowering the quality of patient care.

We also felt that the initially proposed construction cost of \$54.39 per square foot was high and could be reduced to \$49.60 per square foot.

The most important point to note, Mr. Chairman, is that not only was the proposal implemented, but that hospital management observed increased physicians satisfaction with the redesigned facility and higher income levels due to reduced operating expenses in the more efficient facility.

Another way of putting it is that the same number of beds will be available to patients in the community but at a saving of \$300,000 per year.

If such savings are indeed possible, it raises the question, what can be done to prune the excesses from the hospital capital budget? Mr. Chairman, the answer lies in planning. The hospital financing study group believes that sound local planning and rigorous project review at the grass roots level will, for the future, prevent unnecessary additions to hospital bedding and service capacity and will also insure that, when we go ahead with a project, the price tag will be as low as possible.

Thus, we endorse and support the work of the various State and local planning agencies established under Public Law 93-641, under section 1122 of the Social Security Act, and under the certificate of need laws. We are pleased to note that section 4 of S. 1470 will extend the control of the section 1122 planning agencies to operating costs which are directly associated with capital expenditures.

Despite our high hopes for these and other aspects of the bill, Mr. Chairman, I am constrained to offer one caveat of which I am sure you are acutely aware: The most rigorous planning and the most cost-conscious budgeting will not produce miracles. The experience of our members suggests that the overall need for health care capital will remain high. Most of the financings we arrange go, not to expansion of hospital capacity but to necessary upgrading and modernization of existing facilities.

Much of the upgrading and modernization is actually mandated by Federal law or by regulation. In short, even a lean health care capital budget, one from which the unnecessary excesses have been trimmed, will still be substantial.

Mr. Chairman, I turn now to my second point: Congress should take no steps which will raise the cost of health care capital. I am pleased

to say that your bill would not have the unfortunate side effect of increasing the cost of raising private capital for hospitals. Let me try to make my point clear through a brief explanation of the private system of health care capital financing.

Until the early 1960's, hospitals usually raised needed capital through a combination of Federal grants, funded depreciation, and local fund raising drives. Hence, the money to pay for a hospital building program was either at hand or in the pipeline when the ground-breaking took place. In the last 15 years, however, health care capital needs have gone rapidly upward, primarily because hospitals have had to acquire expensive new technologies and to upgrade and modernize their facilities. The demand for health care capital has outstripped the traditional sources of supply. As a result, hospitals have been forced to resort to debt financing. This means simply that the hospital borrows the money to pay for its capital expenditures and then counts on its revenues to pay off the resulting debt. In other words, the hospital behaves pretty much like each of us when we borrow from the bank to buy a house and then depend on our future income to pay off the debt.

But there is one critical difference. In the case of a home mortgage, the real security for the lender lies in an individual's income potential, unrelated to the house itself, and in the ultimate possibility of foreclosure and resale of the property. In the case of hospital financing, on the other hand, projected income is directly associated with operation of the facility and mortgage foreclosure is not a practicable option. There is no ready market of health care entrepreneurs to whom a foreclosed hospital may be sold.

Since hospital foreclosure is not a real option, the lender of health care capital has had to look to the hospital's stream of revenue as the primary security for the loan. In fact, many lenders have insisted on a pledge of gross hospital revenues and on rate covenants under which the hospital guarantees that it will always set its rates at a level which is high enough to meet its debt obligations. In addition, investors have come to expect a projected income level in excess of projected debt payments. Currently, the median debt service coverage ratio for hospital bond issues reviewed by Moody's Investors Service is 1.82.

It is axiomatic in the financial community that the cost of capital is a function of risk. The riskier the investment the higher the rate of interest which the lender will demand; the higher the rate of interest, the more expensive the capital.

We can translate this axiom into the health care scene as follows: any factor which compromises the hospital's stream of revenues injects risk into the investment and raises the cost of the capital. To take a concrete example, HFSG is concerned about the cap on hospital inpatient revenues proposed in title I of the administration's cost containment bill precisely because that cap on revenues would render a rate covenant meaningless.

In essence, it would place a question mark over a hospital's stream of revenues which are its only means of retiring its capital obligations. Hence the administration's bill would raise the overall cost of hospital capital. The ultimate price tag here could be enormous. This point can best be shown by an illustration: hospital bonds rated BBB currently bear interest rates approximately 1 percent higher than bonds rated

A. Such a difference is equal to \$3.4 million during the life of a typical \$15 million loan. That \$3.4 million would be an additional cost to the public and private reimbursement system.

I am pleased, Mr. Chairman, that your bill does not suffer from this defect. Section 2 of S. 1470 specifically excludes capital and related costs from the term "routine operating costs" and hence from the operation of the incentive plan.

We think this exclusion is altogether appropriate since capital costs are unique among health care costs. Once contracted, a hospital's debt obligations are inflexible. They continue through good years and bad. To place capital costs under the same downward pressure as routine operating costs would put a hospital in an untenable bind: it would either have to rob other costs centers to pay its debt obligations in full or it would likely go into default. Either way, its credit rating would be injured and its cost of capital would go up. The key to keeping capital costs to a minimum, as S. 1470 recognizes, is to promote rigorous local planning at the earliest stage of health care development.

There are other ways in which S. 1470 reflects a sophisticated awareness of the necessary role played by private capital in health care. For example, section 3 would make it easier for hospitals to convert or even to retire underutilized facilities. It would make available to hospitals a transitional reimbursement allowance to cover the inevitable capital costs of the conversion or closing.

HFSG supports your efforts, Mr. Chairman, and the efforts of the other members of this subcommittee and of the subcommittee staff, in preparing this thoughtful and constructive piece of legislation. We particularly appreciate those ways in which the bill shows an awareness of the unique and challenging problems of raising private funds for health care capital expenditures. We would be pleased to offer you and the members of your staffs the benefit of our experience in this area.

That concludes my remarks, Mr. Chairman. I would be happy to answer any questions which you or the other members of the subcommittee may have.

Senator TALMADGE. Thank you very much, Mr. Greene, for a comprehensive and well thought out statement.

Is most of your financing for public, nonprofit hospitals or private, for profit hospitals?

Mr. GREENE. Generally for nonprofit hospitals, Mr. Chairman. In fact, in my firm, virtually no part of the business relates to the proprietary hospitals.

Senator TALMADGE. What you are saying in effect is if you put a cap on revenues, hospitals probably could not borrow the money for expansion and meet their needs as they may arise. Is that what you are telling us?

Mr. GREENE. Senator, some hospitals, due to the lack of revenues, would be excluded from the capital markets altogether and would not be able to borrow. Those who are able to borrow would borrow at a very much higher interest rate.

What we are saying is the interest payments, as a result of that, would be passed through directly to the Federal Government which would have to bear the burden of the costs.

Senator TALMADGE. In other words, it would probably have a negative reaction rather than positive?

Mr. GREENE. Exactly.

Senator TALMADGE. Senator Danforth?

Senator DANFORTH. Mr. Greene, do you know any source that we could look to that breaks down the average hospital bill in terms of how much of that bill goes for salaries, how much goes for debt service, how much goes for whatever the other component parts of the bill are?

Mr. GREENE. Senator, in all of the financing that we do, we are aware of the percentage of the daily revenues that are related to debt service.

Senator DANFORTH. You could break that down on a case by case basis?

Mr. GREENE. Yes.

Senator DANFORTH. It would just be case by case. You do not have any aggregate or composite analysis?

Mr. GREENE. Senator, it would very dramatically from one hospital to another, depending on the amount of debt that it has outstanding, when it was borrowed, factors of that nature.

We find for quality hospitals that the average would be between \$10 per patient day and \$20 per patient day. We have seen it as low as \$5 and as high as \$40.

Senator DANFORTH. Do you know of anybody who has done a study of the component parts of a patient's bill?

Mr. GREENE. I do not.

Senator DANFORTH. Thank you.

Senator TALMADGE. There is a vote on the Senate floor now.

Senator Dole, do you have any questions?

Senator DOLE. I will read the testimony. I am sorry I had to be absent.

Senator TALMADGE. Mr. Stewart, if you will excuse us for about 5 minutes, we will come back to hear your testimony. We will go over and vote now.

The committee will stand in recess temporarily, subject to the call of the Chair.

[A brief recess was taken.]

Senator TALMADGE. The subcommittee will be in order.

The next, and final, witness for the day is Dr. Donald H. Stewart, Jr., American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

Doctor, we are honored to have you with us. We expect another vote momentarily on the Senate floor.

You may insert your full statement in the record and summarize it as briefly as you can, and we would be grateful.

STATEMENT OF DR. DONALD H. STEWART, JR., AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

Dr. STEWART. Thank you, Mr. Chairman.

I am from Syracuse, N.Y. I am an active, practicing neurosurgeon and on the staff of the medical school which is the Upstate Medical

Center in Syracuse. The reason I am here is that we are concerned about the health care cost increase and we are concerned about some of the reforms which are going to have to be made to contain the problem.

We come here today in support of the bill being considered. We think it is a reasonable bill. We think it is a workable bill, and we would like to commend you and your subcommittee members for a very thoughtful period which has produced this draft.

The full text of my statement I will not read. I offer it for the record for your consideration.

We support the criteria for determining reasonable costs for hospitals. We like the classification concept introduced dealing with size of hospital, type of hospital, patient mix. We like the idea of excluding energy costs, malpractice insurance, capital costs, et cetera.

Senator TALMADGE. As a neurosurgeon, how much does your malpractice insurance cost?

Dr. STEWART. My insurance last year was \$9,800. I am in upstate New York, which is nice.

Senator TALMADGE. In the city of New York, what would it be?

Dr. STEWART. I think about \$17,000. They are talking about raising it about 250 percent, which is going to be tough.

We think that this section of your bill which deals with payments for closing of hospitals is fair and workable. We like the participating physician concept that you have introduced and we like it because it does not lock an individual in on an all or none basis. Situations may change from time to time and the physician may opt to be in or out.

We are thoroughly in agreement with your attempt to produce a procedural terminology. The two organizations that I represent have spent a lot of time in producing what we call a neurosurgical procedural terminology, which is available to you and to the Secretary of HEW, and it is a compendium of procedures done by neurosurgeons. It uses a five-digit code number system. It has a set of descriptions that are accepted by the neurosurgeons in this country. We have distributed this to neurosurgeons throughout the world in an effort to try to obtain some uniform method of communicating.

It will be adopted by the AMA, CPT, fourth edition, and we hope that the Secretary of HEW and the head of Health Care Financing Agency will not redevelop a whole different series of code numbers and descriptors and further confuse water that is just beginning to get clear.

We do favor your concept of introducing a relative value scale. We think that it would be necessary, at least in terms of trying to predict costs.

We would make one suggestion, and that is that the bill as it now reads, which says regarding relative value schedules that the time and effort involved should be considered, would be made stronger if, in addition to time and effort, the risks involved, the skills required to do a certain procedure or the time required to learn a procedure were entered as factors, because the way the bill reads now, one might think that the slowest and most inept individual would be remunerated at a greater level than someone who is highly skilled.

We applaud the section toward the end of the bill dealing with the disposal of property by medicaid applicants. I think this is an area

of abuse, in some cases, outright fraud, which has gone unattended to for a long time. I have seen several instances where the property of older individuals has gone to the family or others and these people have become the wards of the State or the county.

We would recommend that the section that you have deleted temporarily from this bill dealing with the rate of reimbursement for physicians under the medicaid program, be reintroduced. We realize that this will cost some money.

Senator TALMADGE. That was one of the AMA proposals that we accepted.

Dr. STEWART. Earlier.

Senator TALMADGE. They opposed the provision and we deleted it because they opposed it.

Dr. STEWART. I realize that you did that. I think that we need to consider what we are doing.

If politicians are going to say to people in this country that they have a right to health care, and politicians and people are going to say to the poor and the near poor that you have a right to health care, then they should pay for it.

In the State of New York, physicians are paid about 25 percent or 50 percent, some of them less than that, by the State for services rendered, which, I know, makes the physician, in many instances, subsidize the Government program.

If one is going to be morally responsible—it is tough to be that, and fiscally responsible.

Senator TALMADGE. What percentage of your practice is medicaid?

Dr. STEWART. A very small part.

Senator TALMADGE. Five percent, ten?

Dr. STEWART. I do not know the exact figures. Maybe 5 percent, possibly 10 percent.

Senator TALMADGE. Medicare?

Dr. STEWART. Medicare, probably 20 percent as a rough guess.

Senator TALMADGE. Really, what is going on now, doctors used to do for charity what they are doing now.

Dr. STEWART. That is exactly correct.

I had an opportunity to go to the National Science Foundation recently and hear a man named Mr. Don Lurie who gave a very excellent talk on systems and their development. He made a point that when a system is developed that the individuals who are going to use the system must be present when the analysis of the problem is made, they must be present when the system is developed and they must be present and involved in the implementation stage.

With respect to a lot of the plans that you have made in this bill, I believe that the concept that he presented should be thought about because, as he pointed out, if the individuals that are going to use the system are not present all the way through, the system will get developed and it cannot be impressed downwards on the individuals who are going to use it and it cannot be impressed upwards because of the various human factors relating to cooperating which are inherent.

We have presented for your consideration on the 9th, 10th, and 11th pages of my testimony, a rather politically unsavory suggestion which might answer one of the problems that Mr. Miller brought up earlier this morning. We would suggest that the Health Care Financing Ad-

ministration might provide for advisory panels composed of individuals who come from the various specialty societies who could review the methods of data collection and act in a true evaluating capacity to make certain that there is validity to the data samples which are going to be used which are going to determine physician payment and expenses by the Government.

Some of the data which you may be collecting with respect to physician charges, if you collect it from carriers, may not represent charges. It may, in actual fact, represent what insurance carriers have chosen to reimburse, and I think that one must be very careful.

Senator TALMADGE. We think that kind of review is authorized in the bill.

Dr. STEWART. That is correct; it is. I was suggesting that perhaps the bill could be strengthened and the confidence of those who are going to be subject to the bill be gained by setting up a series of advisory panels so that these individuals know ahead of time, what is being done and what they are going to have to do and that they are going to have to go back to the folks and say, "look, we agreed to that," and not that "Government is impressing that on us."

Senator TALMADGE. That sounds like a valid suggestion. I would appreciate your working with the staff, trying to perfect language along that line.

We have another vote going on in the Senate. I would like to hear more of your testimony, but unfortunately, we cannot be in two places simultaneously.

I am informed you are one of the most able neurosurgeons in the country and you talk like you know what you are talking about. We appreciate your helpful and constructive testimony.

Dr. STEWART. Thank you.

Senator TALMADGE. Senator Dole?

Senator DOLE. Because of the vote, I have no questions. You mentioned the 80 percent provision on page 12. It is your feeling that it ought to be put back into the bill? Is that right?

Dr. STEWART. Yes, I think that would be fair, because if one does not, one is going to be faced with a situation that New York State is faced with, where physicians are not going to shoulder the responsibility of caring for people they do not get paid for.

I think it is morally irresponsible for the State to do what it has done. I told Mr. Constantine about a situation that happened in Syracuse where the State, in order to contain costs for medicaid, developed a new form. The form had to be signed by the physician. If it were not signed on Friday but on a Monday, they, the State would not pay the hospital for the care, and the hospital in turn, billed the physician for the hospital bill.

The right of Government to extend care to the needy and to the poor is great and I support that. I do not think that the State, by being morally irresponsible, should shift the burden for paying for that to the providers.

I think that by reintroducing this section of the bill you will gain the confidence of the provider and improve the lot of those who have been made bereft by actions of States directed by their fiscal problems.

Senator DOLE. Thank you very much.

Senator TALMADGE. Thank you very much, Doctor.

[The prepared statement of Dr. Stewart follows:]

STATEMENT OF DONALD H. STEWART, JR., M.D., REPRESENTING AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

Mr. Chairman, I am an active practicing neurosurgeon in Syracuse, New York, practicing in a hospital setting which combines private practice and teaching in the Upstate Medical Center of the State University of New York. I represent the American Association of Neurological Surgeons and the Congress of Neurological Surgeons whose members are the approximately 2,500 neurosurgeons in this country today.

I am indeed honored to be able to appear before you today to discuss the Medicare-Medicaid Administrative and Reimbursement Reform Act—S. 1470. In reading the bill in detail, we have been impressed by the thoroughness and reasonableness of the bill and would like to congratulate Senator Talmadge and the members of the Subcommittee on this bill which is the product of several years of thoughtful drafting.

I speak for a very small number of physicians, but two societies which are greatly concerned about the problems that our country faces with respect to maintenance of adequate health care. We are likewise concerned about the problems associated with the containment of health care costs and concerned with the reforms which will be necessary to achieve these goals. We do not speak from a power base of political leverage as our numbers are small and we represent less than 1 percent of the physicians in the United States. The neurosurgical community has previously testified on the same concerns before the President's Council on Wage and Price Stability, and I enclose for the record the statement made at that time. I would like to congratulate you on producing a reasoned approach to the problem of containing hospital costs and I feel, as you do, that an effort to contain costs must be phased-in, as you have indicated, by 1981 with the beginning of the long-term plans that you have submitted to begin in 1979.

With respect to the criteria for determining reasonable costs of hospital services, we agree that your classification of hospitals, based upon size, type, and patient mix, is desirable and avoids some of the pitfalls of geographic lumping inherent in other proposals.

We also feel that your definition of routine operating costs, which excludes capital and related costs, direct personnel and supply costs of hospital education and training programs, costs of interns, residents, and non-administrative positions, energy costs associated with heating and cooling of the hospital plant, and malpractice insurance expense, is a wise definition and creates a more workable system. The carrot and stick approach which you have used for under-utilization and over-utilization is reasonable and workable.

In the section of the bill (I, Sec. 2) dealing with State designed reimbursement systems which provide payments to hospitals on a different basis from that contained in this bill, it should be pointed out that this might well work if the State meets its responsibilities in a fair and equitable fashion. However, if the State, because of fiscal problems, mandates payments to hospitals which are far below the reasonable costs and reasonable expenditures required for the care of the people of the State, then adequate appeal mechanisms should be incorporated in the bill to allow for reversal of this type of action by States guided only by their fiscal integrity and not by their concern for human needs.

Recently in the State of New York, in order to contain the costs of caring for patients under Medicaid, a new form was introduced by the State which had to be filled in from time to time by the physician in order for the hospital to be paid. There have been instances when this form was not signed by the physician on the appointed date, but signed two to three days later, and as a result of this the State has refused to pay the hospital for the services that its Medicaid recipient had received and, in turn, the hospital, to collect the monies that it needed to operate, has turned to billing the physician for the cost of hospital care during that interval. States should be rewarded for efficient systems and relative error-free operation, but providers should not be penalized for the failure of the State-designed system.

Payments for closing and conversion of under-utilized facilities seem quite fair. However, others who may be more versed in the economics of this situation may wish to comment differently.

The section dealing with Federal participation in capital expenditures again differs from that proposed by the Administration in H.R. 6575 and in the Senate's companion bill. We agree with Mr. Robert Derzon that the Government must develop a carefully planned allocation of capital . . . because of the old rule of thumb that suggests that each capital dollar invested results in fifty cents per year operating cost increases. Since all capital expenditures exceeding \$100,000 would have to be approved by the Health Systems Agency and the designated State Health-Planning and Development Agency, there is the danger that innovative technological advancements sought by our people could easily be quashed, and it is possible with the make-up of some of the Health Systems Agencies in the United States that individuals not well-versed in the management of health care financing might be placed in the position of not recommending certain capital expenditures. This could result in a diminution of the rate of development and use of new techniques to improve health and reduce suffering. The appeal mechanisms built into your bill for approval of requested funds seem fair and adequate.

We think it is wise that you have left out the provision contained in the House and Senate Hospital Cap bills which would have deducted from the allowed \$100,000 capital improvement any funds or equipment donated by individuals.

With respect to physician assignment, the failure of the bill to lock-in physicians participating in the program on an all-or-nothing basis, we think is desirable, as circumstances may change from time to time and most individuals do not prefer to be coerced into any one position with no options for alternate arrangements.

Under the section of the bill entitled "Criteria for Determining Reasonable Charge for Physician's Services", there is much that can be said. In the section which indicates, "There shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services", there are some questions which should be asked. What is the definition of a similar service? Is the evaluation of a patient by an internist similar and/or the same as that of an evaluation of the patient by a neurosurgeon or by a general practitioner or by a pediatrician? Are all specialty groups to be treated alike or is there to be some differentiation based upon specialty service? Should not the statement read, "For similar services generally made by physicians of similar training"? The item of locality cause some problems. What is meant by locality? Does that mean city, county, state, or region either within a state or a region comprising several states? Are these localities meant to conform to P.S.R.O. areas or otherwise? There has been some confusion on the part of many people, and I think even on the part of various Medicare carriers at the present time concerning what is meant by locality. I have had recent correspondence with one Director of a Medicare intermediary insurance company and his initial letters to me indicated that "locality" meant city. However, when pressed for further information, this definition seemed to become vaguer and larger and it would seem to me that this area of the bill should be better defined.

In the next part of that section (B)(i), it is stated that no charge may be determined to be reasonable if it exceeds the prevailing charge recognized by the carrier for similar services in the same locality in administering this part on December 31, 1970. There are some rather serious problems here and some questions that need to be raised. As you are well aware, the Medicare intermediaries have developed statistical data which they have indicated is valid, but it has been impossible to obtain the data upon which the prevailing charge recognized by the Medicare carrier is based. I am certain that you are also aware of the fact that numerous non-Medicare intermediaries have taken it upon themselves to indicate what prevailing charges are and thus to make payments based upon their statistics. On numerous occasions, large insurance companies well-known to you have refused to submit for evaluation the data upon which they have based the statement that they have determined that the prevailing charge is "such-and-such". I have on no occasion received an answer from a single insurance carrier concerning this data and have been forced into the assumption that the charge leveled by the Federal Trade Commission against some groups of physicians could be easily leveled against various insurance carriers, as it would seem that they have entered into a conspiracy to fix reimbursement, but have been unwilling to release the data upon which they have made these decisions. It would seem to me, therefore, that it would be of ex-

ceedingly great importance that a statistically valid study of the customary charges be made, as indicated in Paragraph (E) of Section 11. There must be a great amount of care given to the consideration that the figures collected from various carriers may represent not the charges submitted to the carriers but either the payments made by carriers or their alleged prevailing charges received by them. Does the prevailing charge level mean the range between the 5th and 95th percentile, the 90th percentile, the median charge, the average charge, or does it mean a figure which the carrier has decided it will pay?

This bill could be strengthened by requiring that the various national specialty organizations, such as the two which I represent today, form review panels consisting of several persons knowledgeable in this area to serve for three-year intervals to advise the Health Care Financing Administration on these matters and to review the data being used to establish Government relative value schedules. Statistical data and information systems can be used in many ways and, if there is to be harmony in the system, perhaps there is some merit to this suggestion as the output of data systems does not always lend itself to correction by the usual appeal processes.

In Section 11 (B) (ii), the statement is made that prevailing charge levels determined for any fiscal year beginning after June 30, 1973 may not exceed the level determined for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economics index data that such higher level is justified by economic changes. What is the definition of, and what is included in, "appropriate economic index data"? This economic index should be revised to account for major differences in geographic areas and specialty practice characteristics and should be flexible and responsive to local situations. It would be best to define this clearly in the beginning rather than in the middle in order that uniformity might be attained.

We wonder about the reasons for making the section on "Criteria for Determining Reasonable Charges for Physicians' Services" take effect upon the enactment of the bill when the situation with respect to hospitals begins at a later date. We also wonder about the propriety of talking about prevailing charges for physicians' services in July of 1975 when we are, even at the present time, nearly two years beyond that. If this lag time is necessitated by inefficient data and information systems, then some thought should be given to usage of newer and functional computer systems which provide analysis with less than an 18-to-24-month delay and which utilize a five digit coding system with its flexibility rather than the four digit code system used by Medicare intermediaries at the present time.

With respect to the consideration of appropriate economic index data mentioned above, it would be our suggestion that a reasonable factor be introduced to cover malpractice insurance and that this be related to specialty and geographic location and procedure frequency. The malpractice insurance premium crisis is not over and there has been recent discussion in the State of California and in the State of New York of again mammoth increases in the size of individual's malpractice premiums, and any such reimbursement program as outlined by you for services rendered to beneficiaries of Medicare and Medicaid must certainly take into account this item.

As an aside, one possible mechanism by which the Government could alleviate the medical liability/product liability problem is to pass a law requiring that all proceeds from such suits and settlements would be taxable as regular income in the year received and not be considered tax-free windfalls as under the present law.

We applaud your intent and desire, under Section 15, in dealing with the establishment of a procedural terminology. The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have for some time been deeply concerned about the difficulties with respect to communication between individuals in one State and individuals in another State, and sometimes even within a State, because of the diversity of numbers used to describe similar events and because of the diversity of written descriptors attached to the code numbers accompanying them. We have published and circulated throughout the entire country and, at this point, throughout the entire world a Neurosurgical Procedural Terminology. This was done after considerable time and effort had been put into trying to make a uniform language, acceptable and usable by all neurosurgeons. This Neurosurgical Procedural Terminology that has been published is available to the Secretary of HEW and the Health Care Financing Administration. It is not a relative value schedule, but indeed is

a compendium of procedures done by neurosurgeons to ease communication between neurosurgeons and neurosurgeons, neurosurgeons and insurance carriers, and neurosurgeons and the Federal and State Governments. The Current Procedural Terminology of the AMA, 4th edition, includes this rather complete and acceptable neurosurgical procedural terminology and we would hope that the Health Care Financing Administration will not develop yet again another system of numbers and descriptors which could very likely confuse an already difficult arena.

Recently I spent some time in Washington and had the opportunity to hear a very fine discussion by a Mr. Don Luria at the National Science Foundation concerning the development of Systems. One of the things he said had been learned was that, in the development of any system, the participants who were to utilize the system must be brought into the development of the system in the very beginning, and that they must be present during the analysis of the problem, during the conceptualization of the reforms needed to solve the problem, and during the final implementation of the plans. He had found that to develop any system in the absence of input and in the absence of participation of those who would be using it created a severe problem in that systems could not be impressed downwards on other individuals or upwards because of the various human factors inherent in the need for cooperation to make the final program operative. We would hope that this type of thinking would prevail when the Health Care Financing Administration recommends to the Secretary of HEW a specific terminology system and a specific relative value schedule.

It is also hoped that in Section 15 (d) (3), the unit values assigned will not only generally reflect the relative time and effort required to perform various procedures and services, but will reflect the risk involved, the time to acquire the skill, and the skill needed in order to perform the various procedures. The bill will be strengthened by the addition of these factors because, as it now stands, the reward is greater for slowness and ineptness than it is for expertise. As you well know, many individuals are quite proficient at performing certain procedures that formerly took them a considerable amount of time. This holds true in areas other than Medicine, and in the bill under this section, there has been no recognition of the factors noted above.

In Section 40 of the bill, it is stated that, "When the payment is based upon the reasonable costs or reasonable charge, no element comprising any part of the cost or charge shall be considered to be reasonable if and to the extent that, that element is among other things a finder's fee." I think that this approach which you have taken is reasonable and I think that some serious questions concerning forwarding fees or finder's fees with respect to the legal professional will have to be raised, as these fees are actually incorporated indirectly in the malpractice premiums which physicians and hospitals are being asked to pay.

With respect to Section 45, which deals with resources of Medicaid applicants, to include certain property previously disposed of to the applicant's relatives for less than market value, we would like to say that we wholeheartedly endorse this section. I have personally seen several examples of transfer of property from an older individual to another member of the family in order specifically to reduce the assets of that individual and make him eligible for Medicaid benefits and thus eligible for support by the general public's taxes. This is an example of fraud and abuse which has gone unattended for a very long time, but which is I think frequent enough to have been addressed in the reasonable way which you have done.

Mr. Chairman, in your initial introductory remarks in the Congressional Record on May 5, 1977, you indicated, "We have found that outright fraud probably costs the taxpayers of this country \$1½ to \$2 billion a year, and we have found that the costs of over-utilization is probably about three times that high." There has been a great hue and cry about fraud and abuse in the last year and part of your recommendations, Mr. Chairman, in the Senate this past year have been incorporated into law, and the discussion has gone on, and the machinery has been set up to counter certain aspects relating to fraud and abuse within the health care arena. This \$1½ billion costs the nation about 1% of the total outlay for health care costs and the over-utilization costs which you cited run between 4½% to 6% of the total bill.

One of the problems which this nation is having is that of coming up with innovative, workable ideas to solve some of the problems associated with the

demand on the various tax revenues. Recently a law was passed which made income derived for sickness disability taxable as income, and removed some of the exemptions previously relating to this income. As a result of that law change, I have personally seen several instances of individuals who had not been working because they had been initially sick, but who had continued not to work because of the fact that they were receiving sickness disability benefits when, in actual fact, their illness had ceased, but the incentive to return to work was considerably less than it should have been because of the remuneration received on a tax-free basis that came to them each week or month. These benefits that they received initially were justifiable and paid for by insurance policies bought with pre-tax dollars. The change in the law, making a considerable part of this income taxable, has forced many individuals to reconsider their primary motivation and to return to work, thus reducing the burden on the premium structure provided to cover sickness benefits. As a side effect of this, there has been a return of productivity by this individual, who had not been working.

Mr. Chairman, you refer to over-utilization of health care facilities, and one of the primary directions of this bill is to limit, in essence, the supply of health care facilities. The problem with dealing with the demand upon health care facilities and health care providers is exceedingly difficult and, as a modest proposal for your consideration which is politically unsavory but which is an idea that might be at least worthy of your consideration, I would like to present to you the concept that health insurance is paid for, for the most part, by pre-tax dollars. When an individual utilizes the services of a physician or comes to a hospital, he, for the most part, does not pay the bill nor is he concerned about the bill because, as has been said many times, "The insurance policy will cover the cost." Now, in actual fact, the insurance policy does cover the cost and the insurance policy has become a wedge separating the consumer from a true evaluation of the costs involved. These pre-tax dollars are used by the individual as one form of income, that is income to pay for health-related needs and, if not needs, health-related desires. The insurance carriers know how much they are paying out in behalf of each individual policyholder, and it would be a simple maneuver for each insurance carrier to formulate at the end of the year a form similar to a W-2 form, which would be sent to the Internal Revenue Service and to the individual, indicating the amount of money expended on his behalf to pay for his medical services. Since the concept of co-insurance does not always work, and since the concept of deductibles does not always work, perhaps it is not unreasonable to suggest that a tax be levied by the Federal Government on this income by individuals. This income tax would have to take into account that there are many poor and near-poor individuals who could not afford to be taxed further than they already are, and it would have to take into account that there are many individuals for whom thousands of dollars are paid each year by their insurance carriers to sustain the cost of a prolonged or catastrophic illness. There should be no tax at the two ends of the spectrum but, in the middle, perhaps an incentive can be built-in which would act to stimulate some consideration by the potential patient of what his true needs are as opposed to his wants.

I do not know about the numbers of people involved in this middle-ground area, but I do know that there are many, many people seen each day in offices of physicians and in emergency rooms of hospitals across the country who really should not be there. This costs money and if we are to pay as much attention as we have legislatively and in the press to outright fraud, then perhaps it would not be unreasonable to give further thought to this concept of taxing income in order to try to stimulate some reduction in demand. If the laws made relating to taxation of sickness benefit income have produced some socially desirable results in our country, then perhaps an additional bonus could be obtained by extension of that concept to that of health care costs and liability costs. This would provide more discretionary dollars to be spent by our citizens, but on the other hand, the present system may be a manifestation of what people really wish to spend their money on to satisfy their needs and wants.

Mr. Chairman, in reading through this bill, I do not note any specific exemption from its terms of Federal hospitals, and it may be that I have overlooked that or that it is an a priori assumption that all Federal hospitals will be exempt from the restrictions and the controls imposed by this bill. If it is true that Federal hospitals are exempted, then one would have to ask whether they operate

with such a degree of efficiency that they do not need to be considered along with the remaining hospitals in the nation covered by this bill. It would be interesting to know the average length of stay of patients in Federal hospitals, and it would be interesting to know the number of employees per patient in Federal hospitals at the present time, as opposed to those outside of the Federal system. It would be interesting to know about the relative cost per in-patient and out-patient of Federal hospitals as related to non-Federal hospitals.

S-1470 formerly contained a section which would have required States under their Medicaid programs to pay physicians not less than 80% of what Medicare pays. This section has been temporarily deleted because of opposition which felt that this 80% would become a ceiling rather than a floor. It was also opposed by the Governors Conference because this provision would have cost several hundred million dollars. The nation, through its Medicaid programs, has attempted to provide for the poor and near-poor a quality of care equal to and commensurate with that obtained by every other American. If one looks at the remuneration of physicians on the State of New York, one will find that reimbursement for care of Medicaid recipients in many instances is 50%, or even 25%, of that under other programs. As a result of this, many physicians have chosen not to subsidize Government programs, and have not extended their services to these unfortunate individuals made bereft by the attempts of States to conserve funds. These Medicaid recipients are individuals who also have been told by politicians that they have a right to health care. It would seem reasonable to discuss the matter further with those who have opposed it, and we think it would be responsible to re-introduce that section of the bill just alluded to, in order to eliminate the two-class system which has been created by Government. The remuneration made by Federal and State Governments for care rendered to recipients of Medicaid benefits must be the same as that under any other system. However, only in extreme circumstances should the level of support of such services drop from parity to 80%. I realize that that would cost money, but perhaps some of this money could be obtained by reducing the rather enormous administrative costs relating to this type of program, and emphasizing cost effectiveness for the benefit of the poor and near-poor in the United States.

I thank you for the privilege and honor of appearing before this Subcommittee today, and will answer any questions you might have at this time.

PRESENTATION TO PRESIDENT'S COUNCIL ON WAGE AND PRICE STABILITY

(By Donald H. Stewart, Jr., M.D. representing the American Association of Neurological Surgeons and The Congress of Neurological Surgeons)

The American Association of Neurological Surgeons and The Congress of Neurological Surgeons are two organizations representing approximately eighty percent of the neurosurgeons in the United States. As a group, we number less than one percent of the physicians in the United States but we, as you, are concerned about the problems associated with the rising health care costs in our country. We have been attempting to become informed about the various factors contributing to this problem and are pleased to participate in the hearings which you are holding here today.

It would seem that the basic issue to be dealt with is one related to the question of how much can we as a people afford to pay for health care. We expended \$118 billion this past year for health care which is a considerable sum. The rate of increase in the costs has been alarming and to put the question in a larger perspective, perhaps it would be of a value to indicate that in this past year we as a nation spent \$52 billion for casualty and liability insurance. We spent in excess of \$100 billion for education. We spent \$150 billion for housing, \$141 billion for household operation, \$185 billion for food, \$124 billion for transportation, \$65 billion for recreation, \$39 billion for alcohol and tobacco. These figures are from the Department of Commerce, Bureau of Economics Analysis.

The areas of our specific concern are the problem of rising hospital costs and rising physician costs. It is our understanding that physician costs have gone up at approximately the same rate as that of the general inflationary rate, but hospital costs have far exceeded the inflationary rate. It is our understanding that in this past year approximately \$27 billion was paid by private insurance carriers for health care and that \$50 billion was paid by Federal, State, and local governments for health care, and that \$34 billion was paid by individuals for health care.

It would seem, in trying to analyze the factors related to increased hospital costs, that they can be allocated into three general areas. There are specific government and legal actions which have contributed to increased costs: the increase in the minimum wage, the increase in Social Security payments, required compliance with retirement laws, increased unemployment insurance, increased costs for utilization review programs, required tests for in-patients, and code compliance activities, to mention but a few.

The development of new services in hospitals has very definitely increased the costs of running hospitals. To give an example of some of those new services being introduced, one should recall the rapid expansion of nuclear medicine facilities, computerized axial tomography, neo-natology units, drug and alcohol abuse programs, and full time emergency room physicians.

There have been forces in the marketplace which have been quite difficult to predict and which the hospital cannot easily control which have contributed to the increased costs. The cost of energy alone has rapidly escalated. As you know, there has been a considerable amount of publicity just recently concerning the increased cost of malpractice insurance to hospitals. The costs of supplies bought by hospitals have been of considerable importance in contributing to the costs of the hospital stay. The increased costs related to hospital worker unionization and the cost of borrowing capital because of lack of grants and gifts must be considered.

There are similar factors responsible for increased physician costs. There has been an obvious increase in the overhead of running a physician's office, consisting of increased telephone charges, increased rent, increased salaries to personnel, retirement plan compliance, not to mention the considerable increases which have occurred just recently in malpractice insurance which at the two ends of our country now ranges between \$20,000 and \$40,000 per year, whereas just a few years ago it was \$1,000 to \$2,000 per year. The effect of inflation is certainly a factor to be considered here as well as in the hospital cost area. The increased amount of taxes which are paid is of considerable import. In the year 1975, taxes paid increased more than any other item in the average budget.

In considering the problem of increased costs, it is interesting to note what actions have been taken by Government to decrease the revenues available to pay for the costs. Various Government programs have mandated losses under the reimbursement formulas. There has been evidence of non-participation of medicare in certain direct costs relating to patient care and there has been reduction in payment rates to hospitals to offset the value of unrestricted gifts to hospitals, which in effect has reduced the effectiveness of benevolence. Now there has been evidence of retroactive denial of payment for services provided by hospitals. The Cost of Living Council actions of the recent past mandated losses for hospitals.

Perhaps the most disturbing feature about medical care costs are related to hospitals is the fact that it is well advertised that the Consumer Price Index for health care relating to hospital costs is rapidly escalating in the two digit range. Discussion with several persons knowledgeable about hospital costs would indicate that the true cost to the hospital is not reflected by the Consumer Price Index figures. The true cost to the hospital for the services it provides is less than the Consumer Price Index would indicate and the reason for this is somewhat complex but can be explained reasonably simply.

The reimbursement to the hospitals for services provided by Blue Cross, Medicare and Medicaid amounts to a sum less than the actual cost and the disparity is increasing constantly. This means that the hospitals, and particularly those that have a large proportion of Medicare and Medicaid and Blue Cross patients, are operating at a deficit in order to care for these patients. They, in turn, to make up for this deficit, charge a higher rate to the private insurance carriers and to those self-pay individuals, hoping to make up for the deficit occasioned by the lack of payment for services by the third party carriers noted above. This results in an inflated charge (or price) structure to enable the hospital to meet its actual costs and to take up the slack in the third party programs. The Consumer Price Index draws on these published charges to develop its statistics on hospital costs. This produces an artificial and inaccurate result with regard to what is going on in the area of a hospital's true operating costs. Thus the Consumer Price Index is artificially high and reflects in part the above problem. This aberration must be recognized and dealt with if we are to make a proper data base from which to draw proper conclusions concerning health care costs.

As a result, a good part of the costs for providing health care to those persons covered under Blue Cross, Medicare, and Medicaid is being shifted from the purported carrier to the private insurance industry and to self-pay individuals. Because of this, it has become obvious that some of the private insurance carriers are having difficulties meeting the demands placed upon their premium pools and some have already left the Major Medical insurance field and others are reducing the payments which they will allow and putting the burden for payment of these bills back on the provider and/or the consumer. There have been, as a result of this failure on the part of some carriers to pay the actual costs, a consideration on the part of some very large hospitals of giving up their contracts with Blue Cross which will place severe restrictions on the availability of medical care to those covered under these programs at this time. Perhaps the most peculiar feature is that the system as now operating introduces a very real double taxation to the wage earner who with one hand pays taxes to support the cost of Medicare and Medicaid and with the other hand pays increasing premiums for health care either in the form of higher premiums or greater out-of-pocket costs to subsidize the tax supported portions of health care costs.

As pointed out by Professor Martin Feldstein, Professor of Economics at Harvard University, perhaps the major problem to be considered is the availability of insurance itself. As he quite nicely pointed out in his testimony before the Subcommittee on Health of the Committee on Ways and Means on July 24, 1975, the availability of insurance has produced a system which requires and sustains the introduction of more and more costly services. Thus services have up until this point, been bought by premium dollars with very little out-of-pocket cost to the patient. But as he also pointed out, the product bought by the insurance is considerably different now, not only in cost but in quality, than it was a number of years ago. A number of years ago a quart of milk was a quart of milk, and it remains the same today. However a day in the hospital today is quite different from that of a number of years ago with respect to the sophisticated and complex modalities available.

One of your panel members inquired in the hearings in New York City as to why it costs more in Medicine to do something better—that is to provide a quality product with respect to medical care—when in industry, as productivity increases and the product improves the cost goes down. There is a difference between the automatic, mass machine-produced, high quality but lower price product of industry and the sophisticated assessment and delivery of health care as a product. The two products are really quite different. We now, through either government insurance programs or private insurance programs, have wonderful care available for the treatment of renal disease, including renal dialysis and renal transplants, in addition to the well-known open-heart surgery. One of the ironies is that the hospital industry is accused of not keeping costs down and has become the bad guy in recent rhetoric. Hospitals for the most part are not-for-profit institutions. They do not set the charges for the products they buy from industry—industry does. The hospital is not making a profit by charging more—it is merely trying to pay its bills to industry which is making the profit, but industry is not the bad guy—it is the health delivery system.

One other peculiar irony is that if a 500 bed hospital reduces its length of stay by twenty-five percent by introducing efficiency methods, then in essence it is increasing its bed capacity by twenty-five percent, or by 125 beds. At the going cost of about \$80,000 per bed in new hospital construction, this amounts to a savings of \$10 million in potential capital expenditures. This type of saving is occurring but is not being recognized.

It is true that these products of modern medicine are expensive and it is also true that they benefit a very small proportion of the population. We in Neurosurgery have available now microsurgical techniques which are being applied to more and more conditions, particularly to the treatment of strokes and the revascularization of the brain. The removal of brain tumors is now much more easily accomplished and much more completely accomplished using microsurgical techniques, and the heretofore very high morbidity and mortality have been reduced considerably. The introduction of computerized axial tomography, which is really in its first generation and which is very expensive, has eliminated in many instances prolonged hospitalization for diagnostic purposes and has eliminated in many instances the costly and somewhat dangerous procedures such as angiograms, pneumoencephalograms and in some instances, myelograms. All of these advancements cost money. There is no question that these expensive items

in the milieu of the practice of medicine have improved the quality of medicine, but it is also true that they have improved it for a relatively few people.

It is obvious to those of us who practice Neurosurgery that the reduction in morbidity and reduction in hospital stay and more rapid return to work, occasioned by the use of these more sophisticated modalities, has resulted in an enormous savings in dollars for the segment of the population with which we deal. Neurosurgeons deal with many types of head injuries and the most outstanding example in the last few years of preventive medicine and its cost-saving to the public has been in this area. With the reduction in the speed limit and with the greater awareness of the population about the dangers inherent in driving and drinking, there has been a 25 percent reduction in head injuries and a considerable saving in terms of medical costs to the population as a whole. We are, however, still concerned with the, as yet incomplete, development of a society-wide concept of preventive medicine and are greatly concerned with the fact that there are still approximately 75,000 persons per year who die of carcinoma of the lung, which has been felt in large part to be due to the effects of smoking. We are still concerned with the 28,000 automobile-related deaths which have been in one way or another caused by the consumption of alcohol, and we are concerned about the 11.5 million injuries which occur in our country as a result of accidents each year, which result in nearly half a million permanently disabled individuals with no small attendant medical cost. We feel that these areas, among others in the area of preventive medicine, could well, if emphasized, lead to further cost reduction to our population as a whole and a shift of the dollar presently being spent on health care to other areas such as education and housing, which would improve the esthetic value of the lives of our citizens.

Finally, we would like to indicate our thoughts concerning the proposed budget for fiscal year 1977 in which it was indicated that there would be a 7 percent limit on increase in hospital charges and a 4 percent limit on physician fees. There was no mention of limitation on other areas in the marketplace and if this policy of the Government is allowed to stand, then the Government will have departed further from the concept of paying the cost of what it gets, and the result will be an even higher Consumer Price Index for the cost of health care as it is now figured. The loser will be the tax paying consumer whose health care is funded through the private insurance industry, as this consumer will be charged even more than he is at the present time to make up for the deficits created by the failure of the Government to pay the true cost of the goods received. This will inevitably lead to a more chaotic situation and, with fewer private insurance carriers in the field, a greater role would have to be played by the Government with the attendant higher taxes to support the administration of such a plan and to support the very institutions required to provide health care for the people of our country.

Another of your Commission inquired of a former speaker at these hearings as to how National Health Insurance would allow cost controls. It is difficult to imagine after reading the Report on Cost and Quality of Health Care by the Committee on Interstate and Foreign Commerce, published in January 1976, that the Government could effectively impose cost controls. In the State of New York, the Governor has indicated that the administrative costs of the Medicaid program are in excess of 50 cents on the dollar after ten years of operation.

We feel, as others do, that there must be built into any system of insurance a certain disincentive to spend the premium dollar, in part to keep us solvent and in part to keep us from becoming neurotic. We would favor the concept of a degree of co-insurance with any type of plan making it necessary for the consumer to pay the first dollar amounts of any costs commensurate with his true ability to pay this cost. There are administrative problems here and some feel that the health care provider should not collect the first dollar but that the carrier should, whether it be the Government or the private insurance carrier. Regardless of how it is done, unless there is an immediate and not distant financial disincentive to utilize the health care system and its expensive gadgets, there will be continued over-utilization of expensive services and escalation of costs.

We must come to grips with the fact that if the people want the very best, and they do, then the very best will have to be paid for. We must also devise a rational and acceptable way of differentiating our true needs from our wants.

Senator TALMADGE. The committee will now stand in recess until 8:30 tomorrow morning.

[Thereupon, at 11:05 a.m. the subcommittee recessed to reconvene Friday, June 10, 1977, at 8:30 a.m.]

MEDICARE AND MEDICAID ADMINISTRATION AND REIMBURSEMENT REFORM ACT

FRIDAY, JUNE 10, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 8:35 a.m. in room 2221, Dirksen Senate Office Building. Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Curtis and Dole.

Senator TALMADGE. The subcommittee will please come to order.

The first witness this morning is Mrs. Liane Levetan, commissioner, De Kalb County, Ga., on behalf of the National Association of Counties.

It is a distinct pleasure for me, as chairman of the subcommittee, to welcome a warm, personal friend and a valued constituent to testify before our subcommittee this morning. You may insert your full statement in the record, please, Ms. Levetan and, due to the large number of witnesses, we must necessarily limit your testimony to 10 minutes.

You may insert your full statement and summarize it in 10 minutes.

STATEMENT OF LIANE LEVETAN, COMMISSIONER, DE KALB COUNTY, GA., AND MEMBER, HEALTH AND EDUCATION POLICY STEERING COMMITTEE OF THE NATIONAL ASSOCIATION OF COUNTIES, ACCOMPANIED BY MIKE GEMMELL, LEGISLATIVE REPRESENTATIVE

Ms. LEVETAN. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I am Liane Levetan, commissioner, De Kalb County, Ga. I am also a member of the Health and Education Policy Steering Committee of the National Association of Counties—NACO—on whose behalf I am appearing today. With me is Mike Gemmell, NACO legislative representative.

The National Association of Counties represents over 1,500 county governments which together comprise 90 percent of the Nation's population. The vast majority of the counties in this country provide public health and medical care services.

By the way, Mr. Chairman, as a representative of county government, I was made aware by one of your able staff members of the proper place counties have in our Federal system. He reminded me that even though States have greater visibility in our intergovernmental structure, they are, after all, only clusters of counties.

NACO supports S. 1470 with suggested amendments. We see S. 1470 as an opportunity for Congress to take the necessary steps to bring hospital cost increases under control. We are concerned about hospital costs because counties pay 10 percent of the annual \$17 billion—and growing—medicaid bill. This figure does not contain the costs of medical care to the unsponsored patients. In addition, counties own more than 10 percent of the hospitals—45 percent of the public general hospitals—in this country.

Attached is a NACO survey which clearly shows that the commitment of county governments to the medicaid program is substantial. As health care costs increase, counties are being forced to rely on an already burdened property tax to support the health care of a small segment of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated service responsibilities to the burgeoning fiscal requirements of the medicaid program. Cutbacks in services and/or eligible population provide no relief for counties, which are traditionally the providers of last resort.

Persons whose major health problems fall into special categorical problem areas, and others whose lifestyles disqualify them for protection under Federal health programs, including disabled but working persons, children of intact families, childless couples, single persons between 21 and 65 years old, the working poor, nonresident aliens, prisoners and migrants, must turn to local government for help.

However, our Nation's approach to the medically indigent or unsponsored patients through medicaid is uneven and highly inequitable. Inadequate benefits in some States create classes of medically needy which do not even exist in other States. These medically indigent persons also become the burden of local government.

We testified before another Senate health subcommittee on the administration's hospital cost control proposal—S. 1391. The administration acknowledged that their proposal is a stopgap solution which will only treat one result of basic health care organization deficiencies; that is, the high cost of hospital care. We appreciated the political realities which dictate this particular short-term approach, at this time. However, for the long term, incentives must be incorporated into any cost containment proposal to encourage use of ambulatory care, outpatient services, and home health care agencies. We believe that S. 1470 is an attempt to seek a long-range solution to basic reform of medical care in this country.

Mr. Chairman, we support the goals of S. 1470. We believe that the following suggestions would assist counties in seeking their own solutions to holding down skyrocketing hospital costs.

First, S. 1470 must contain greater incentives to place higher priority on outpatient versus inpatient care. As you know, medicare, medicaid, and private insurance all provide greater coverage for inpatient care than for outpatient services. In many counties, the recovery rate is only 50 percent for outpatient services. In some other counties, the recovery rate is only 50 percent for outpatient services. In some other counties, the recovery rate is less—often close to zero.

In many places, patients who could be inexpensively treated as outpatients are admitted to expensive hospital beds so that more of their

costs are covered. Other patients do not receive early treatment and preventive services which could avoid expensive hospitalization.

Facilities and personnel to provide outpatient services are not available where they are needed. Capital and operating support for neighborhood health centers and surgi-centers would mean that more patients could be treated at remote sites that are easily accessible to patients, instead of inexpensive and inconvenient hospital emergency rooms and clinics. S. 1470 should provide payment mechanisms for outpatient services at reasonable cost to act as an incentive for outpatient rather than inpatient care.

Second, S. 1470 should contain a provision that helps public medical facilities to meet the costs incurred for treating unsponsored patients. We suggest that the Congress close the present gaps in medicaid by adopting the following amendment to title XI, section 1115, of the Social Security Act by adding a new subsection that states:

(C) Under such terms and conditions as the Secretary may prescribe, he may waive all plan requirements under title XIX, section 1902, with respect to funds appropriated by general purpose local governments for the purchase of medical care to those individuals not receiving aid or assistance under title XIX and/or who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, and that the Secretary may consider such funds as an allowable non-Federal share of the expenditures incurred for services to individuals not covered under the State plan or title XVI.

Third, S. 1470 should contain a provision prohibiting private hospitals from dumping unsponsored patients on public hospitals. Some private hospitals might go beyond their 120-percent gap in their category.

Fourth, S. 1470 should allow public hospitals to go over their ceiling when and if States broaden their medicaid benefit packages or liberalize medicaid eligibility requirements. Public hospitals would, under S. 1470, be penalized if States changed their medicaid plan requirements to include greater numbers of eligible recipients.

As a protection against dumping, we urge the Congress to provide increased financial assistance to health systems agencies (HSA's). As presently funded, HSA's are unable to monitor hospitals against any type of dumping.

Finally, we strongly support the provision in S. 1470 which recognizes that any charge for a service or procedure performed by a physician is reasonable if "the service is performed in an area designated as a physician shortage area."

We recognize the urgent need for incentives to bring health care services to underserved areas. Manpower shortages are particularly severe in rural counties. The U.S. Department of Health, Education, and Welfare estimates that 26 million people reside in rural medically underserved areas.

Further, we urge that S. 1470 include a provision which would allow for medicare reimbursement to clinics for physician assistants or nurse practitioner services. Medicare restrictions against payment for mid-level practitioner services have created a bias against rural areas, many of which rely on these health professionals for primary care services.

In summary, Mr. Chairman, we support the intent of S. 1470. We thank you for allowing us the opportunity to give our views on this

bill that seeks long term solutions to rising hospital costs that are beginning to place financial burdens on county governments. We are willing, at your direction, to work with staff in seeking enactment of S. 1470 with the amendments suggested in our statement.

Thank you, Mr. Chairman. It was my pleasure to present our views before your subcommittee.

Senator TALMADGE. Thank you very much, Mrs. Levetan, for a very thoughtful and analytical statement and helpful suggestions. We would appreciate the Association of Counties' continuing to work with our staff in attempting to perfect the bill.

This committee is delighted that the National Governors' Conference, the Association of Counties, the National Association of Legislatures, as well as virtually every other facet of health care and delivery service in the nation has worked with us for several years in perfecting this bill. We appreciate their support.

We want to count on you further for further cooperation.

Ms. LEVETAN. Thank you. We certainly do appreciate the efforts that you have put into this.

Senator TALMADGE. Senator Dole?

Senator DOLE. I have no questions. I share the comments made by the chairman.

Particularly on page 4 of your statement. I am pleased to see the reference to inclusion of a provision that would allow for medicare reimbursement to clinics, physician assistants and nurse practitioner services. As you indicate, this is a matter of great interest in the rural areas, coming from the rural Midwest area. We think that it would be very helpful.

I know that there are a number of different views floating around. Perhaps we can work them out.

Ms. LEVETAN. We discussed this at length in a policy meeting in Milwaukee a couple of weeks ago. This is one of the consensus opinions.

Senator TALMADGE. I think that is an excellent suggestion. Certainly, the subcommittee, when we will mark up the bill, will include that, especially for underserved rural areas, one of the critical needs in the Nation.

Senator Curtis?

Senator CURTIS. I have no questions.

Senator TALMADGE. Thank you very much.

Ms. LEVETAN. Thank you so much.

[The prepared statement of Ms. Levetan follows:]

STATEMENT OF HON. LIANE LEVETAN, COMMISSIONER, DE KALB COUNTY, GA., ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Mr. Chairman, members of the subcommittee. I am Lian Levetan, commissioner, De Kalb County, Georgia. I am also a member of the health and education policy steering committee of the National Association of Counties (NACo)¹ on whose behalf I am appearing today. With me is Mike Gemmell, NACo legislative representative.

¹ NACo is the only national organization representing county government in America. Its membership includes urban, suburban, and rural counties joined together for the common purpose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government; serving the national spokesman for county government; acting as a liaison between the Nation's counties and other levels of government; and, achieving public understanding of the role of counties in the Federal system.

The National Association of Counties represents over 1500 county governments which together comprise 90 percent of the nation's population. The vast majority of the counties in this country provide public health and medical care services.⁷

By the way, Mr. Chairman, as a representative of county government, I was made aware by one of your able staff members of the proper place counties have in our federal system. He reminded me that even though states have greater visibility in our intergovernmental structure, they are, after all, only "clusters of counties."

NACo supports S. 1470 with suggested amendments. We see S. 1470 as an opportunity for Congress to take the necessary steps to bring hospital cost increases under control. We are concerned about hospital costs because counties pay 10 percent of the annual \$17 billion (and growing) medicaid bill. This figure does not contain the costs of medical care to the "unsponsored patients." In addition, counties own more than 10 percent of hospitals (45 percent of the public general hospitals) in this country.

Attached is a NACo survey which clearly shows that the commitment of county governments to the medicaid program is substantial. As health care costs increase counties are being forced to rely on an already burdened property tax to support the health care of a small segment of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated service responsibilities to the burgeoning fiscal requirements of the medicaid program. Cutbacks in services and/or eligible population provide no relief for counties, which are traditionally the providers of last resort.

Persons whose major health problems fall into special categorical problem areas, and others whose life-styles disqualify them for protection under federal health programs (including disabled but working persons, children of intact families, childless couples, single persons between 21 and 65 years old, the working poor, non-resident aliens, prisoners and migrants) must turn to local government for help. However, our nation's approach to the medically indigent or unsponsored patients through medicaid is uneven and highly inequitable. Inadequate benefits in some states create classes of medically needy which do not even exist in other states. These medically indigent persons also become the burden of local government.

We testified before another Senate health subcommittee on the administration's hospital cost control proposal (S. 1391). The administration acknowledged that their proposal is a stop-gap solution which will only treat one result of basic health care organization deficiencies, that is, the high cost of hospital care. We appreciated the political realities which dictate this particular short term approach, at this time. However, for the long term, incentives must be incorporated into any cost containment proposal to encourage use of ambulatory care, outpatient services and home health care agencies. We believe that S. 1470 is an attempt to seek a long range solution to basic reform of medical care in this country.

Mr. Chairman, we support the goals of S. 1470. We believe that the following suggestions would assist counties in seeking their own solutions to holding down skyrocketing hospital costs.

First, S. 1470 must contain greater incentives to place higher priority on outpatient versus inpatient care. As you know, medicare, medicaid, and private insurance all provide greater coverage for inpatient care than for outpatient services. In many counties, the recovery rate is only 50 percent for outpatient services. In some other counties, the recovery rate is less—often close to zero.

In many places, patients who could be inexpensively treated as outpatients are admitted to expensive hospital beds so that more of their costs are covered. Other patients do not receive early treatment and preventive services which could avoid expensive hospitalization.

⁷ Over 75 percent of the 3000 counties are administratively responsible for providing community health services. Over 68 percent provide medical assistance, 60 percent provide mental health services, 30 percent operate hospitals (nearly half of public hospitals are county operated), 38 percent provide emergency medical services, and 26 percent operate long-term care facilities. Counties also provide traditional public health services: immunization programs, sanitation, home health, school health, V.D. clinics, well-baby clinics, alcoholism and drug abuse prevention and treatment, family planning, etc. To a large extent, these services are financed by local funds. Census data shows that counties spent \$3 billion for hospitals and \$1 billion for community health services in 1975. In 1966, counties spent \$1.3 billion and \$311 million, respectively.

Facilities and personnel to provide outpatient services are not available where they are needed. Capital and operating support for neighborhood health centers and surgi-centers would mean that more patients could be treated at remote sites that are easily accessible to patients, instead of inexpensive and inconvenient hospital emergency rooms and clinics. S. 1470 should provide payment mechanisms for outpatient services at reasonable cost to act as an incentive for outpatient rather than inpatient care.

Second, S. 1470 should contain a provision that helps public medical facilities to meet the costs incurred for treating "unsponsored" patients. We suggest that the Congress close the present gaps in medicaid by adopting the following amendment to title XI, section 1115, of the social security act by adding a new subsection that states:

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Fourth, S. 1470 should allow public hospitals to go over their ceiling when and if States broaden their medicaid benefit packages or liberalize medicaid eligibility requirements. Public hospitals would, under S. 1470, be penalized if States changed their medicaid plan requirements to include greater numbers of eligible recipients.

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Finally, we strongly support the provision in S. 1470 which recognizes that any charge for a service or procedure performed by a physician is reasonable if "the service is performed in an area designated as a physician shortage area."

We recognize the urgent need for incentives to bring health care services to underserved areas. Manpower shortages are particularly severe in rural counties. The U.S. Department of Health, Education and Welfare estimates that 26 million people reside in rural medically underserved areas.

Further, we urge that S. 1470 include a provision which would allow for medicare reimbursement to clinics for physicians assistants or nurse practitioner services. Medicare restrictions against payment for mid-level practitioner services have created a bias against rural areas, many of which rely on these health professionals for primary care services.

In summary, Mr. Chairman, we support the intent of S. 1470. We thank you for allowing us the opportunity to give our views on this bill that seeks long term solutions to rising hospital costs that are beginning to place financial burdens on county governments. We are willing, at your direction, to work with staff in seeking enactment of S. 1470 with the amendments suggested in our statement.

Thank you, Mr. Chairman. It was my pleasure to present our views before your subcommittee.

THE ROLE OF COUNTY GOVERNMENT IN MEDICAID: A SURVEY OF SELECTED STATES

(By James Koppel, Survey Director; and John F. Clark, Survey Analyst;
National Association of Counties)

INTRODUCTION

This study by the National Association of Counties (NACo) demonstrates the financial and administrative commitment of county resources to the Medicaid program. Although the Medicaid program is generally considered to be a federal-state partnership, local county governments are required to provide substantial financial and administrative support. In five of the fifteen states surveyed for this study, county governments paid over 20 percent of the total

Medicaid program or administrative costs for the fiscal year July 1, 1975 to June 30, 1976.

NACo maintains that the funding of the Medicaid program should be completely assumed by the federal government. This position is based upon three observations: (1) Medicaid plans vary from state to state; thus, the medically indigent residing in one state are commonly denied services available to those in other states; (2) counties must fill the gaps in services to the poor; thus, Medicaid programs which provide fewer services place a greater workload on county health agencies and hospitals; and (3) those states which require county support in Medicaid funding increase the burden on the major source of county revenue, the local property tax.

The purpose of this report is to demonstrate the burden the Medicaid program places on county government, to outline the major gaps in services to people, and to emphasize the need to address this problem in discussions concerning the reform of the Medicaid program. The escalating costs of the Medicaid program (\$2 billion per year since 1974) have strained county budgets to the point where other mandated services areas are being jeopardized. Assumption of funding for the Medicaid program by the federal government would relieve counties of this burden, and enable them to maintain their efforts in other areas of responsibility including public health and medical care.

ACKNOWLEDGEMENTS

The data presented in this report were obtained from officials working in the agencies responsible for the individual state medical assistance plans. In many cases, more than one official was consulted; however, the name of only the principal contact is provided for each state. The NACo staff wishes to express its appreciation to those state officials who provided the data necessary to complete this study.

METHODOLOGY

The survey was designed and directed by James Koppel of the NACo staff. John Clark authored the survey analysis.

Data for this report was obtained through personal interviews with officials of the departments responsible for administering the individual state medical assistance programs. Interviews were conducted between March and June, 1976. Where necessary, figures were projected to cover the fiscal year July 1, 1975 to June 30, 1976. The accuracy of the data, where available, was considered to be good. In some cases information could not be readily obtained from existing records, e.g., the number of state-operated skilled nursing and intermediate care facilities was in several cases unknown.

A total of fifteen states were interviewed, representing 47 percent of the country's Medicaid recipients (1973 figure). Geographical dispersion was obtained by selecting states located in the Northeast, South, Midwest, and West. Patterns in the provision of services, and participation in funding by the counties were identified.

Two types of costs were looked at for this report. Program costs were defined as costs for services provided. Administrative costs were defined as the costs associated with operating the Medicaid program, e.g., the costs of determining the eligibility of a recipient.

FINDINGS

Table 1 displays the states surveyed, the type of program operated (medically needy or SSI type), the optional services provided, and whether counties fund either the program or administrative costs of Medicaid.

Nine of the fifteen states operated a "medically needy" program, i.e., medical assistance was provided to poor persons other than those receiving AFDC or SSI. In seven of these nine states, counties participated in funding the program costs of Medicaid. In three of these states counties also contributed to the administrative costs of the program.

Six of the fifteen states operate a "categorically needy" program, i.e., eligibility for medical assistance is based upon qualification for either AFDC or SSI assistance. In three of these states counties pay part of the administrative costs of the program. One state, Nevada, has property taxes earmarked for the Title XIX fund. In eleven of the fifteen states surveyed (or 73.3 percent), coun-

ties are required to financially support the Medicaid program. The other thirty-nine states are not required to financially participate in the Medicaid program. However, most counties in these states finance the bulk of medical services to medically needy persons that are not covered under Medicaid.

Opposite this requirement of financial support by the counties, the degree of county control over the program, i.e., as far as the setting of standards for eligibility and the setting of benefit levels was reviewed. (Data are presented on individual state survey sheets.) In all fifteen states, standards for eligibility were set by the state. In fourteen of fifteen cases, the level of benefits was likewise determined solely by the state, Nebraska being the exception. The costly process of determining the eligibility of potential recipients was assigned to the counties in all but three states.

Table 2 presents the program and administrative costs of Medicaid to county governments from July 1, 1975 to June 30, 1976. Table 3 displays the percentage of total (federal and state) Medicaid costs funded by county governments for the same period. For those states having the medically needy program, the counties generally (7 or 9 cases) were required to assist in funding Medicaid costs ranging from 2.4 percent to 27.5 percent of total programs costs. Support of administrative costs ranged from 2.88 percent to 35.4 percent of total administrative costs.

Table 4 displays the per capita contribution by county governments to Medicaid program and administrative costs. These figures were obtained by dividing the contribution of each state's counties to program (and administrative) costs by the average monthly served population multiplied by twelve. The highest per capita contribution to program costs occurred in those states having the medically needy program. The highest per capita contribution to administrative costs was paid by Indiana counties (\$13.17) and was nearly ten times the size of the next largest (New York at \$1.34).

CUTBACKS

Between January 1, 1975 and January 15, 1976 five of the surveyed States (Ala., Md., N.H., N.J., Va.) reduced or eliminated mandatory or optional services to Medicaid recipients. Three more states (Ind., Nebr., N.C.) plan to reduce or eliminate services in fiscal 1977. The goal of reductions or eliminations in services provided under the states' Medicaid plans is cost control; the effects will surely be an increased burden on local governments, which are mandated to provide health services to their indigent populations.

States which have the medically needy program were slightly more likely to cut back on services than states with the more restricted SSI program (4 to 3).

County participation in Medicaid funding did not seem to prevent cutbacks in services. States in which counties funded Medicaid were as likely to cut back services as those states in which counties did not. Since county funding of Medicaid will continue, the ultimate losers in any cutback of services are the counties. The escalating costs of health care will require continued support by the counties at levels equal to or exceeding those of the past fiscal year. Meanwhile, those services to the poor that are no longer covered under Medicaid must be provided solely at county expense. A cutback in services or eligible population, while possibly serving the state's need for economy, only worsens the situation of the counties.

SUMMARY

This report has pointed out that the commitment of county governments to the Medicaid program is substantial. As health care costs increase, counties are being forced to rely on an already burdened property tax to support the health care of a small segment of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated service responsibilities to the burgeoning fiscal requirements of the Medicaid program. Cutbacks in services and/or eligible population provide no relief to counties, which are traditionally the providers of last resort. The effective response requires the federalization of Medicaid.

TABLE I.—SERVICES (OPTIONAL)

Program type ¹	STATES PROVIDING SERVICE															
	AL	CA	CO	IN	MD	MN	NE	NV	NH	NJ	NY	NC	OH	VA	WI	
	S	M	S	S	M	M	M	S	M	S	M	M	S	M	M	
Clinic service.....		X		X	X	X	X	X	X	X	X	X	X	X	X	
Prescribed drugs.....	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Dental services.....		X		X	X	X	X	X	X	X	X	X			X	
Prosthetic devices.....	X	X	X	X	X	X	X	X	X	X	X		X			
Eyeglasses.....	X	X			X	X	X	X	X	X	X			X	X	
Private duty nursing.....				X			X	X				X	X		X	
Physical Therapy.....		X	X		X			X	X	X	X			X	X	
Preventive Rehab.....		X						X	X		X		X		X	
Emergency Hospital.....	X	X	X		X			X	X	X	X	X	X	X	X	
SNFS patients under 21.....		X	X	X				X	X	X	X		X		X	
Optometry.....	X				X			X	X	X	X	X	X		X	
Podiatry.....		X	X		X	X		X	X	X	X	X	X	X	X	
Chiropractors.....				X		X		X	X	X	X	X		X	X	
LTC within ICF.....	X	X	X		X	X		X	X	X	X	X		X	X	
Mental illness in geriatric care (65).....	X	X	X	X				X	X	X	X	X		X	X	
Participation in funding ²		B	A	A	P	B	P	(³)	P		B	B	A			

¹ M—medically needy program; S—SSI eligibility program.

² P—counties contribute to program costs; A—counties contribute to administrative costs; B—counties contribute to program and administrative costs.

³ County property taxes exceeding \$3,600,000 are put into the State title XIX fund.

TABLE 2.—PROGRAM AND ADMINISTRATIVE COSTS TO COUNTIES JULY 1, 1975–JUNE 30, 1976

Aggregated county costs	Program (amount)	Administrative (amount)
State:		
Alabama.....		
California.....	¹ \$313,573,044	
Colorado.....		\$151,660
Indiana.....		² 16,370,000
Maryland.....	4,457,511	
Minnesota.....	13,405,573	1,393,750
Nebraska.....	13,228,000	
Nevada.....		
New Hampshire.....	3,917,550	
New Jersey.....		
New York.....	754,000,000	18,694,000
North Carolina.....	¹ 19,035,000	
Ohio.....		1,100,000
Virginia.....		
Wisconsin.....		

¹ Covers both program and administration.

² \$5,004,000 was reimbursed from Federal funds.

TABLE 3.—PERCENTAGE OF TOTAL MEDICAID COSTS FUNDED BY COUNTIES JULY 1, 1975 TO JUNE 30, 1976

State	Program costs	Administrative costs
Alabama.....		
California.....	¹ 15.0	¹ 15.0
Colorado.....		2.88
Indiana.....		35.4
Maryland.....	2.4	
Minnesota.....	4.4	25.0
Nebraska.....	20.3	
Nevada.....		
New Hampshire.....	11.8	
New Jersey.....		
New York.....	27.5	24.0
North Carolina.....	² 4.7	² 4.7
Ohio.....		10.0
Virginia.....		
Wisconsin.....		

¹ 15 percent of the total program and administrative costs.

² 4.7 percent of the total program and administrative costs.

TABLE 4.—PER CAPITA CONTRIBUTION BY COUNTRIES TO MEDICAID PROGRAM AND ADMINISTRATIVE COSTS
JULY 1, 1975-JUNE 30, 1976

[In per capita dollar amounts]

	Program	Administrative
State:		
Alabama.....	0	0
California.....	(1)	(1)
Colorado.....		\$0.18
Indiana.....		13.17
Maryland.....	\$0.89	
Minnesota.....	10.06	1.05
Nebraska.....	32.89	
Nevada.....		
New Hampshire.....	14.67	
New Jersey.....		
New York.....	54.23	1.34
North Carolina.....	(2)	(2)
Ohio.....		.25
Virginia.....		
Wisconsin.....		

¹ Program and administration total equal \$21.78.² Program and administration total equal \$9.70.

Note: California and North Carolina reported program and administrative costs as 1 figure.

UPDATE—OTHER STATES WHICH HAVE COUNTY CONTRIBUTIONS
TO THE MEDICAID PROGRAM

FLORIDA

I. Inpatient hospital care

The counties of Florida pay 35 percent of the non-Federal share for inpatient hospital care recipients beyond 12 days following admittance. This amounted to \$4,306,546 in fiscal year 1976 (total expenditure: \$45,871,447).

II. Skilled nursing and intermediate care

The counties pay 35 percent of the non-Federal share for recipients costing more than \$170 a month. This cost can not go above \$55 a month per recipient. The fiscal year 1976 cost to counties in Florida was \$8,651,433 (total expenditure: \$73,900,070).

NORTH DAKOTA

	Percent	Amount
Federal.....	58.0	\$13,763,364.62
State.....	35.7	8,471,588.22
County.....	6.3	1,494,986.16
Total.....	100.0	23,729,938.00

The counties also pay 50 percent of the administrative expenses which occur at the county level (eligibility determination, caseworkers, overhead costs, etc.)

PENNSYLVANIA

The counties paid 45 percent of the cost for county nursing care. There are 45 county nursing homes in Pennsylvania and the total cost to these homes, for fiscal year 1976 was \$40 million of the \$88 million total. Starting in fiscal year 1977 the state will begin to share the cost of the non-federal share.

[In percent]

	Federal	State	Local
Fiscal year:			
1977.....	55	11.25	33.75
1978.....	55	22.5	22.5
1979.....	55	33.75	11.25
1980.....	55	40.5	4.5

Senator TALMADGE. The next witness is M. Gail Moran, staff director, Committee on Human Resources, National Governors' Conference.

Miss Moran, you may insert your statement in full in the record and summarize it in 10 minutes, if you will, in the interests of time.

STATEMENT OF M. GAIL MORAN, STAFF DIRECTOR, COMMITTEE ON HUMAN RESOURCES, NATIONAL GOVERNORS CONFERENCE

Ms. MORAN. Thank you, Mr. Chairman.

First, I do ask that I would like to submit a report issued by the National Governors' Conference on Medicaid Reform. Your staff has been tremendously helpful in coordination of our work with the committee's work, and I would like to place our report on medicaid reform in the record as an appendix to my testimony.*

Mr. Chairman, members of the committee, I am Gail Moran, staff director of the Committee on Human Resources, National Governors' Conference. I am delighted to have this opportunity today to share with you some of the concerns of the Governors regarding the rising cost of health care and the increasing burden of the medicaid program upon State governments and, therefore, upon the taxpayers. Under the leadership of Governor Richard F. Kneip of South Dakota and Governor George Busbee of Georgia, the Nation's Governors recently called for sweeping reform of the medicaid program. At this juncture, I must acknowledge the unending support and valuable advice provided by your staff to the Governors during their deliberation.

As you, Mr. Chairman, stated in your introductory remarks on May 4, medicaid/medicare would cost Federal and State taxpayers more than \$38 billion in fiscal year 1977. It is estimated that these programs will cost Federal and State taxpayers more than \$47 billion in fiscal year 1978.

Medicaid has become the most rapidly escalating cost in State budgets and the largest item in many local government budgets. In some States, the amount of money spent on medicaid for a person's health is greater than that of a person's welfare benefits. Both State and Federal Governments approach a time when they may be financially unable to provide adequate assistance for the poor and the medically indigent. This is unconscionable and cannot be allowed to happen. The spiralling cost of this program must be controlled, but without holding the poor hostage to forces beyond their control. The fundamental issues here are the need for better control over the rates paid for health services and the utilization of those services by patients.

Mr. Chairman, the Governors agree with the National Conference of State Legislatures in their testimony earlier this week that "the choice is a simple one; either we make medicaid/medicare more efficient and economical or we reduce benefits." Faced with increasing budgetary restraints and astronomical increases in benefit and medicaid expenditures, States have either been forced to cut the scope of services offered or reduce the number of individuals served under the program. Neither course of action solves the problem.

Although spiraling medicaid budgets are partly due to an increased number of recipients, and partly to expanded benefits, the real culprit

* See p. 321.

has been the dramatic rise in the cost of services, particularly hospital services. Cost-based reimbursement has had an inflationary impact on hospital costs by providing virtually no incentives for efficiency or cost containment. Until reasonable cost is defined to include considerations of efficiency and prudence, costs probably will continue to escalate.

Governors are alarmed by the apparent lack of fiscal restraint within the entire health care industry. It is exceedingly difficult, if not impossible, to contain escalating costs in medicaid/medicare expenditures unless viable methods are found to control unreasonable cost increases within all sectors of the health care industry. Moreover, it is unrealistic to expect the States to control health care costs simply through more effective administration and policy changes in the medicaid program. Finally, to control medicaid costs while ignoring the spiraling costs of the insurance programs may act as an incentive to providers to deny services to medicaid recipients.

If the reimbursement system is to control health costs effectively, a uniform policy, which applies to all hospital payers, is required. Therefore, we would recommend the expansion of provisions in § 1470 to encompass reimbursement control. The freedom of choice provision guaranteeing the patient the option of choosing individual physicians and hospitals can only be guaranteed if we prevent a dual payment system which discriminates against the poor and aged.

Within this realm, the Federal Government should allow States wider flexibility in developing and implementing methods of reimbursing health care providers—particularly in establishing allowable costs. Alternative reimbursement methods should extend to all payers.

State medicaid programs must satisfy a variety of federal requirements in developing a system for reimbursing providers of medical services. For example, noninstitutional providers (Physicians, Dentists) are paid by medicaid on the basis of a fee schedule which cannot exceed the related medicare payment profile. Prescription drugs can be reimbursed either on the basis of maximum allowable cost or estimated acquisition cost as prescribed in federal regulations. States must reimburse hospitals and nursing homes for the "reasonable cost" of inpatient services.

In providing for reimbursements to institutional providers, States must comply with Federal regulations that ensure the amounts reimbursed under medicaid do not exceed those reimbursed under medicare. Several States have established baseline items for reimbursement to hospitals (and in some instances nursing homes) as provided in the medicare formula. Federal approval is required if a State plan contains a system of cost-related reimbursement for nursing homes. The only alternative to methods prescribed in Federal regulations for reimbursement to hospitals is to secure a waiver from HEW.

The degree to which the Federal Government regulates medicaid reimbursement methods varies with the type of provider. States have the least control over nursing homes and hospital reimbursement, although such reimbursements comprise the largest portion of most State medicaid budgets. Until 1972, for example, States were required to use the medicare system for determining the "reasonable cost" of inpatient hospital reimbursement. Even though this requirement was relaxed, only four States have received HEW approval to control

costs. Many additional States are seeking HEW approval but are stifled by HEW delay.

Subject to Federal evaluation and final approval, States should be allowed to institute alternative methods of reimbursement for institutional providers and fee schedules for noninstitutional providers, consistent with the principle of providing adequate health care. HEW should review and revise its current reasonable cost criteria (which States believe are not cost effective), but the department should not attempt to set fee schedules. The States, if they so choose, should be responsible for developing fee schedules from HEW's revised criteria.

One vital issue ignored by this legislation is the treatment of long term care facilities. In recent hearings, Governor Garrahy said that "the problem of the fiscal impact of institutional type services on the medicaid program is best illustrated by an examination of the expenditure of skilled nursing and intermediate care facilities. Forty percent of the national medicaid expenditures is attributed to payments for these services." We face the very real possibility that medicaid funding will be controlled and overwhelmed by such expenditures, unless alternatives for institutionalized care can be developed and adequately funded.

Congress and the administration, in cooperation with the States, must develop a coherent national policy for health and social care of the elderly. This policy must endorse use, wherever appropriate, of alternatives to traditional long-term care. Such alternatives should be substantially financed by federal funds, as institutional care is now financed. If the Federal Government continues to encourage the use of traditional institutions to care for elderly persons by providing financial assistance mainly for this type of care, States will have to seek full Federal assumption of the costs of this care.

The only way to begin to solve this problem is to make available for all elderly citizens a complete continuum of care, including ambulatory services, medical and nonmedical day care, adult foster care, homemaker services, transportation services, long-term care facilities and acute hospital care. States can develop such a continuum only if Federal financial assistance for alternative care is available in at least the same proportion as for long-term institutional care. Federal funding, in far greater amounts than is now available from any source, particularly Title XX, must be provided—whether through Title XVIII, Title XIX, or another existing or new source.

In addition to increased Federal funding for alternative care, a cohesive national policy for health and social care of the elderly should include: (1) Financial incentives, including tax incentives, for families that continue to provide care and shelter for their elderly; (2) increased State latitude in combining funds from federally matched health and social programs to meet special needs of the elderly; (3) Federal financial assistance and flexibility for States that experiment with new treatment and care methods believed to be more cost effective and humane; and (4) federally funded research to determine the most appropriate kinds of care for elderly persons in various states of health.

If these types of assistance—particularly the greatly increased Federal financial assistance for alternatives to institutional long-term

care—are not provided, the expensive, needless and inappropriate mushrooming of institutional long-term care will continue unabated and threaten the entire Medicaid program. States will then have no alternative but to ask the Federal Government to assume the full cost of long-term care.

While advocating that any cost control measures must encompass all payers, the Governors insist that the States be allowed to administer their own programs. Former Governor Woodrow Wilson of New Jersey once said that "States are the laboratory of democracy." The involvement of States in health cost containment is an excellent example of the commitment to regulating that industry. Historically, State government has been involved in health cost containment through the regulation of insurance companies. In recent years, numerous States, Maryland, Massachusetts, New York and Washington among them, have enacted statutes which require State approval of the rates for medical care services. Therefore, we urge that not only those States currently operating ratemaking agencies be allowed to maintain their agencies but also other States be allowed to operate independent programs, as long as such programs are as stringent as the Federal statute. Further, if any State wants to impose a ceiling lower than that of the Federal statute, it should be allowed to do so without lengthy and difficult appeals. Federal legislation should encourage State experimentation with alternative hospital reimbursement mechanisms.

The Governors share your desire for the expanded provision of technical assistance to the States. Technical assistance provided by the Federal Government has been inadequate by and large. If such Federal assistance is to continue, the Medical Services Administration staff in Washington within the first two years of their employment, should be required to obtain on-site State experience. We also recommend that Federal law encourage interstate technical assistance through Federal reimbursement. The talent between and among the States is significant and should be tapped.

We support development of appropriate criteria to gauge State performance. Governors are concerned that Medicaid be managed in the most efficient manner possible. However, the question remains whether the bill's proposed criteria and enforcement mechanisms would achieve that goal. Many States probably would have problems meeting these requirements in the specified time. As we indicated earlier in the testimony, we support increased technical assistance, especially in this management area. We do not support penalty provisions but recommend replacing them with positive fiscal incentives; we, therefore, support the bill's provisions that encourage this end.

Thank you.

I also wish to recognize the comments made by the National Association of Counties and echo our support for efforts to get medical manpower into rural, underserved areas. Governor Hunt and Governor Busbee are two Governors in the Appalachian Regional Commission. The ARC supports this position and we would be glad to add our assistance to that.

Senator TALMADGE. Thank you very much, Miss Moran, for an excellent testimony. As you pointed out in your testimony, Medicaid is

almost bankrupt in most of the States. The only reason it has not bankrupted the Federal Government is that we can print money and the States cannot. The Governor's Conference has been very helpful in helping us prepare this legislation. We are grateful for their support. We ask your continued cooperation in trying to mark up the prospective bill.

Senator Curtis, do you have any questions?

Senator CURTIS. I have no questions.

Senator TALMADGE. Thank you very much.

[Excerpts from the report referred to follow. The complete report was made a part of the official files of the committee. Oral testimony continues on p. 332.]

EXCERPTS FROM THE REPORT OF THE TASK FORCE ON MEDICAID REFORM, NATIONAL GOVERNORS' CONFERENCE, FEBRUARY 1977

INTRODUCTION

At the July 1976 Summer Meeting, the nation's Governors passed a resolution declaring that Medicaid reform was "an item of highest priority" and called on the National Governors' Conference "to provide leadership in working with Congress and HEW to develop needed reforms." Following that meeting, former NGC Committee on Human Resources Chairman, Cecil D. Andrus, asked that I chair a task force, representing eleven States, to carry out this mandate.

As a result of the initial meeting held in Atlanta in September, the task force was organized into subcommittees to define issues and develop policy recommendations. Following this meeting, I mailed a full report of the proceedings to all Governors.

The recommendations were modified and refined during a series of task force meetings. Ten regional meetings were held in December to obtain the comments and suggestions of the Governors not represented on the task force. Final recommendations were approved by the Committee on Human Resources at their January 21 meeting.

Enclosed for your review, modification, and approval are the results of the Medicaid Task Force's efforts. Accompanying the proposed NGC policy to be considered at our Winter Meeting is in executive summary which discusses in brief fashion each of the key points recommended in the overall policy statement.

You will find some of the proposed policy very specific, while some tends to propose more general principles. This is because we often found numerous opinions on how Governors ought to address a particular aspect of Medicaid reform. However, it is my firm belief that these recommendations place us in an excellent position to initiate or react to more specific proposals over the next few months.

GEORGE BUSBEE,

Governor of Georgia.

POLICY STATEMENT ON MEDICAID REFORM

While the purpose of Medicaid is sound—medical assistance for the poor—the design and administration of the program have produced a system which is bankrupting the States and their localities.

Medicaid has become the most rapidly escalating cost of state budgets and the largest item in many local government budgets. In some States, the amount of money spent by Medicaid for a person's health care is greater than that person's welfare benefits. Many governments approach a time when they will be financially unable to provide adequate assistance for the poor and medically indigent. That is unconscionable and cannot be allowed to happen.

The spiraling cost of this program must be controlled, but without holding the poor hostage to forces beyond their control. The fundamental issues are the need for better control over the rates paid for health services and the utilization of those services by patients.

State governments, which are responsible for the management of the Medicaid program, must intensify their efforts to manage the program better. To accomplish this, the federal government, in cooperation with the States, must revise

existing regulations and legislation which pose obstacles to effective and efficient management of the program at all levels.

The National Governors' Conference has analyzed and debated possible reforms in financing, services delivery, organization and administration of the Medicaid program. From this effort, the Governors are united in supporting certain principles and recommendations regarding Medicaid reform, while recognizing that there may be other methods or means to achieve these reforms.

Organization and Administration

1. Federal health care finance functions should be consolidated into one major division of the Department of Health, Education and Welfare (HEW). This new division would develop a framework of consistent and uniform health care policies for all citizens. Accompanying such a consolidation should be a careful study and clarification of the roles and functions to be performed by regional office personnel.

2. The Medicaid technical assistance role of HEW should be strengthened, with added emphasis on onsite training of federal staff in the States.

3. A comprehensive program for the detection, investigation and prevention of recipient and provider fraud and abuse within the Medicaid program should be developed, with emphasis on improved coordination between Medicaid personnel and federal, state and local law enforcement agencies.

4. State management of the Medicaid program should be strengthened by:

Replacing negative program penalty provisions with positive fiscal incentives for improved state management;

Implementing the Medicaid Management Information System (MMIS) or an acceptable comparable alternative in all States;

Developing federal framework policy manuals and provider agreements, for use by States at their discretion, which would provide consistent information on programs and clear intent on policies; and

Increasing the federal matching ratio for state Medicaid administration to 90 percent if States meet certain performance criteria.

5. HEW must take the lead in establishing a common data base for use in developing fee structures for each provider type, based on information available to every health care program.

6. HEW must simplify all medical reimbursement systems and should establish for federally supported programs a fixed hierarchy of first-to-final responsibility for payment on behalf of persons eligible for two or more benefit plans.

7. Prior to the implementation of proposed regulations, reports and standards, HEW should be required to perform an impact study emphasizing both fiscal and service delivery areas.

8. HEW should establish a central depository of information on policies, procedures and data systems used throughout the country which have proven successful.

9. A natural subrogation policy (assignment of all residential health care or insurance benefits while eligible for public assistance) for categorically and medically eligible recipients in the Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC) programs should be adopted.

Financing

1. Congress should give immediate consideration to alternative methods by which the spiraling costs in the health care industry could be brought under control more effectively.

2. Federal legislation should be enacted to allow States wider flexibility in developing and implementing methods of reimbursing health care providers—particularly in establishing allowable costs. Alternative reimbursement methods should extend to all payers, and federal health planning programs should be coordinated with reimbursement programs.

3. Because of changes in the program and among the States since the Medicare law was enacted, the present formula ought to be examined by Congress to determine if there are more acceptable methods of deriving the federal financial share.

4. The current system of enforcing fiscal and program accountability within state Medicaid programs should be altered by specifically directing any management fiscal sanctions and eliminating program fiscal sanctions. Increased emphasis should be placed on positive financial incentives for improved state management (as measured by acceptable levels of program performance).

5. The federal government should finance from general revenues the full financial obligation of copayments and deductibles for Medicare recipients also eligible for Medicaid.

Delivery of Services

1. In the interest of economy, States should be allowed to determine which health service providers a recipient may choose, if the same quality care can be purchased at a lower cost.

2. Federal regulations should be changed to give States wider authority to impose realistic and appropriate sanctions against recipients who willfully overutilize Medicaid.

3. SSI eligibility rules should be amended to prohibit divestiture of personal assets for the purpose of becoming eligible for SSI and Medicaid benefits.

4. Congress and the Administration, in cooperation with the States, must develop a coherent national policy for health and social care of the elderly. This policy must endorse use, wherever appropriate, of alternatives to traditional long-term care. Such alternatives should be substantially financed by federal funds, as institutional care is now financed. If the federal government continues to encourage the use of traditional institutions to care for elderly persons by providing financial assistance mainly for this type of care, the States will have to seek full federal assumption of the costs of this care.

5. The law and regulations should be changed to allow States to contract with Professional Standard Review Organizations (PSROs) and to review and approve proposed PSRO policies to ensure that these functions are reasonably accountable to the States.

6. States should be allowed to implement a nominal copayment on mandatory services for categorically eligible Medicaid recipients.

7. States should be allowed to restore family supplementation for Medicaid patients in nursing homes.

The nation's Governors are convinced that reform toward these ends can help bring the costs of the Medicaid program under control without reducing the availability or quality of care to the poor. Unless such reasonable, strong and immediate action is taken by the federal government, the States cannot promise to supply these needed services at the requisite levels, for they will be unable to afford them.

EXECUTIVE SUMMARY—ORGANIZATION AND ADMINISTRATION

1. Federal health care finance functions should be consolidated into one major division of the Department of Health, Education, and Welfare (HEW). This new division would develop a framework of consistent and uniform health care, policies for all citizens. Accompanying such a consolidation should be a careful study of clarification of the roles and functions to be performed by regional office personnel.

To provide more cohesive and uniform management of the major health care functions under the Social Security Act, those functions presently within HEW should be consolidated into one major division, whose administrator would report directly to the HEW Secretary. This consolidation would include at least the services under Title V, Title XVIII and Title XIX of the Social Security Act; plus HEW's Office of Long-term Care, the Bureau of Quality Assurance and the Bureau of Health Planning and Resources Development. Consolidation is not intended to dilute the authority or identity of state-administered programs but rather to promote sounder federal management of health programs.

Consolidation of all federal programs responsible for reimbursing, setting standards and delivering health care will be a giant step towards a uniform and consistent health care policy for all citizens.

Such a reorganization would affect regional offices as well as the central office. HEW should reevaluate the role of regional offices in terms of their relationship with the central office and with the States. One of the most critical needs of States is to have a unified health care policy and a consistent interpretation of the policy from State to State and region to region.

The areas of responsibility within the new division would be overall policy determination and coordination, budget recommendations, allocation of funds, supervision of programs, research and program evaluation.

The major objectives of the new division should be to:

(a) Reduce the complexity of medical care programs by consolidation and elimination of overlapping functions and activities;

(b) Establish consistent standards and limitations governing the payments to providers to help curb the apparently limitless spiraling of medical care costs; and

(c) Develop uniform reporting procedures with common data elements and standard definitions of terms, including a Common Chart of Accounts for institutional cost reporting.

The new division would make it far easier for States and other governmental agencies to communicate their needs and problems regarding health care delivery.

2. The Medicaid Technical Assistance (TA) role of HEW should be strengthened, with added emphasis on onsite training of federal staff in the States.

Technical assistance provided by the federal government has been inadequate by and large. If federal technical assistance is to continue, the medical services administration staff in Washington should be required to obtain onsite State experience within the first two years of employment.

With today's sophisticated computers and accounting systems, it is vitally important to have adequate and competent staff to provide technical assistance. While HEW does have competent staff, there are too few of them and the demands on their time are too great. If States are to comply with federal regulations and contain costs, adequate technical assistance must be provided either through restructuring and expanding the federal program or allowing the States to contract for technical assistance on one-time projects.

States have not been able to hire staff with the level of competence needed in many of the more technical areas of the Medicaid program, including fraud and abuse, data processing, cost accounting, medical service delivery and outreach for nearly periodic screening, diagnosis and treatment. The federal government could either provide this expertise or allow the States to contract for it.

3. A comprehensive program for the detection, investigation and prevention of recipient and provider fraud and abuse within the Medicaid program should be developed, with emphasis on improved coordination between Medicaid personnel and Federal, State and local law enforcement agencies.

Prevention and elimination of fraud and abuse in the Medicaid program are crucial goals. While the Governors commend the Federal government for recent enforcement efforts and encourage coordination between the Inspector General, the Social and Rehabilitation Services Fraud and Abuse Section and the U.S. Attorney General, there must be more cooperation between federal, state and local law enforcement and other involved agencies to eliminate fraud and abuse by providers and recipients. The Governors pledge their continuing support for these efforts and full cooperation by state law enforcement agencies.

To effect appropriate enforcement efforts the States must be able to identify fraud and abuse and must ensure that offenders are prosecuted or suspended by the proper authorities. In addition, the Federal government must ensure that offenders convicted in one State not be allowed to practice in any other State. A central record-keeping system would prevent medical care providers from participating in the Medicaid and Medicare programs if they have been convicted or suspended from participation in Title XIX programs. Detection of fraud and abuse can be improved through a more sophisticated use of the MMIS' Surveillance and Utilization Review Subsystem, supplemented with sampling of recipients through the Explanation of Medical Benefits system.

4. State management of the Medicaid program should be strengthened by:

Replacing negative program penalty provisions with positive fiscal incentives for improved State management;

Implementing the Medicaid Management Information System (MMIS) or an acceptable comparable alternative in all States;

Developing Federal framework policy manuals and provider agreements, for use by States at their discretion, which would provide consistent information on programs and clear intent on policies; and

Increasing the Federal matching ratio for State Medicaid Administration to 90 percent if States meet certain performance criteria.

The States can plan and develop health care delivery more effectively and efficiently than a federally administered program. However, administration must be strengthened to provide a more cost effective medical care program for the poor and underprivileged. State management would be improved through:

(a) positive fiscal incentives (see Financing).

(b) implementing the Medicaid Management Information System (MMIS) or an acceptable alternative in all States. (The administration of the Medicaid program has been hampered in many States by a lack of information. The development of the MMIS system is a good example of how various States can utilize the best systems resources in other States to develop and refine their own procedures.)

(c) developing federal "framework" policy manuals and provider agreements, for use by States at their discretion. HEW should develop clear, thorough and frequently updated program manuals and provider agreements to provide the States with consistent information on programs and to clarify the intent of policies. States would then be able to modify these manuals as necessary, based on State laws and experiences.

(d) increasing the Federal match for State administration to 90 percent for States meeting established performance criteria. HEW should also, in consultation with the States, establish performance criteria for administration of the Medicaid program. States meeting all these criteria should be reimbursed 90 percent of their administrative expenses. In no instance should a State receive less than 75 percent reimbursement.

Additionally, Governors are committed to improving the management of the Medicaid program by focusing the necessary attention on the state program and obtaining through state legislative channels the resources necessary to accomplish these goals.

5. HEW must take the lead in establishing a data base for use in developing fee structures for each provider type, based on information available to every health care program.

The dependence on the record-keeping and budgetary processes of institutional providers makes it extremely difficult to derive current and accurate fee structures for reimbursement. Conversely, the problems in deriving fee structures for noninstitutional providers are complicated by a dependence on data from the Medicare program or, in the drugs, from HEW's Medical Services Administration.

One methodology must be developed and used universally so that data systems will be compatible for the exchange of information and identification of unusual patterns of reimbursement or unusual fees.

6. HEW must simplify all medical reimbursement systems and should establish for federally supported programs a fixed hierarchy of first-to-final responsibility for payment on behalf of persons eligible for two or more benefit plans.

At present there are 53 distinct and different Medicaid programs. The size and scope of these programs vary significantly, with different services, different forms of reimbursement and different billing procedures.

With today's modern computer technology, there is absolutely no reason for States to process the present massive amounts of paper. Almost every hospital and a number of physicians have access to technology which is capable of building a computerized record as a claim for reimbursement from the state Medicaid program. HEW should identify common data elements and their relationship to Federal and State Medicaid requirements with the purpose of introducing a common billing form and uniform billing cycles for providers to claim reimbursement.

Additionally, Medicaid is the payor of last resort for all third-party carriers. Therefore, other programs such as Medicare must communicate with Medicaid, not vice versa. The more commonality that can be achieved, the better the Medicaid program can function.

The Federal government should establish clear and definitive guidelines on the responsible payor and the extent of that responsibility as it relates to other government programs. Information exchange systems can then be developed along more systematic lines to take into account third-party liability such as private insurance, Medicare, vocational rehabilitation or other programs that are controlled directly or indirectly by Federal or State governments.

7. Prior to the implementation of proposed regulations, reports and standards HEW should be required to perform an impact study emphasizing both fiscal and service delivery areas.

The implementation of new regulations or administrative activities mandated by HEW has proven cumbersome and difficult in a number of instances.

Frequently, state legislative action, either through appropriations or enabling legislation, is required to implement new or changed HEW policies. States are left with few choices other than reactive planning. Such lack of consideration for

the fiscal impacts and the possible changes in service delivery mechanisms and administration necessary to comply places both Federal and State governments in a position of questionable accountability.

Congress should require HEW to determine the impact of proposed regulations or federally mandated administrative activities on the Federal government, States, providers of health care and recipients, as applicable. This determination should entail an accountability to Congress and include, but not be limited to fiscal impact, service delivery impact, secondary impact on States and lead-time requirements. States will participate in these studies as needed and supply the desired information.

8. HEW should establish a central depository of information on policies, procedures and data systems used throughout the country which have proven successful.

Although there is disparity in state administered Medicaid programs, there is also a great deal of commonality and uniformity of purpose. However, available techniques, methodology, data systems, policies and procedures must be centrally organized so that they can be shared among States with similar problems. HEW is to be commended for actions already taken toward this goal. Continued efforts by HEW could result in early establishment of a central depository of information.

Such a system should have the capabilities of providing instantaneous access and more detailed information as needed. Reinventing the wheel is costly, time-consuming, and serves no useful purpose. However, there has been much reinventing during the ten-year history of Medicaid because of the lack of a central depository of information.

9. A national subrogation policy (assignment of all residual health care or insurance benefits while eligible for public assistance) for categorically and medically eligible recipients in the supplemental security income (SSI) and aid to families with dependent children (AFDC) programs should be adopted.

SSI eligibility is now determined by the Social Security Administration for almost every State. Using federal standards, States control the determination of AFDC benefits.

If a recipient has additional health resources or benefits available at the time medical services are rendered, such resources should be used to pay for the cost of care, with Medicaid assuming responsibility for any remaining portion of the medical bill.

It is now almost impossible for data systems to identify other resources available to the recipient when medical services are rendered. The States believe a recipient with additional health resources or benefits should be required to turn over such resources so that they might be applied toward the cost of medical care.

States should consider alternatives for dealing with this problem. At least one State has a law that requires every provider to notify the Title XIX agency of any bill to another payor on behalf of a person eligible under Title XIX. States may also be able to modify provider agreements toward this end.

FINANCING

1. Congress should give immediate consideration to alternative methods by which the spiraling costs in the health care industry could be brought under control more effectively.

One of the major problems facing all state Medicaid programs is the rapid rise in the costs of adequate health care. The Governors are alarmed by the apparent lack of fiscal restraints within the health care industry.

It will be exceedingly difficult, if not impossible, to contain escalating costs in Medicaid expenditures unless reasonable methods are found to control unreasonable cost increases within all sectors of the health care industry. Moreover, it is unrealistic to expect the States to control health care costs simply through more effective administration and policy changes in the Medicaid program. Finally, to control Medicaid costs while ignoring the spiraling costs of other insurance programs may act as an incentive to providers to deny services to Medicaid recipients.

There are several alternatives by which adequate health care could once again be afforded by the average American family. For example, one alternative would be the establishment of a health care policy board within HEW. Such a board

could develop national policy on the financing of health care through private and public insurance and categorical funding, control rates within the health care industry nationwide, plan health care delivery under the National Health Planning and Resources Development Act (PL 93-641) and facilitate coordination among existing state health care rate commissions and health systems agencies.

Another alternative would be to establish health care policy boards on state or homogeneous regional levels.

Other alternatives exist. In essence, if fiscal restraints in the Medicaid program are to be effective, Congress, the Administration, the States and the health care industry can no longer afford to delay serious consideration of alternative methods to control rising health care costs.

2. Federal legislation should be enacted to allow states wider flexibility in developing and implementing methods of reimbursing health care providers—particularly in establishing allowable costs. Alternative reimbursement methods should extend to all payers and federal health planning programs should be coordinated with reimbursement programs.

State Medicaid programs must satisfy a variety of federal requirements in developing a system for reimbursing providers of medical services. For example, noninstitutional providers (physicians, dentists) are paid by Medicaid on the basis of a fee schedule which cannot exceed the related Medicare payment profile. Prescription drugs can be reimbursed either on the basis of maximum allowable cost or estimated acquisition cost as prescribed in federal regulations. States must reimburse hospitals and nursing homes for the "reasonable cost" of inpatient services.

In providing for reimbursements to institutional providers, States must comply with federal regulations which ensure that amounts reimbursed under Medicaid do not exceed those reimbursed under Medicare. Several States have established baseline items for reimbursement to hospitals (and in some instances nursing homes) as provided in the Medicare formula. Federal approval is required if a state plan contains a system of cost-related reimbursement for nursing homes. The only alternative to methods prescribed in federal regulations for reimbursement to hospitals is to secure a waiver from HEW.

The degree to which the federal government regulates Medicaid reimbursement methods varies with the type of provider. Hospitals and nursing homes, which account for the largest portion of most state Medicaid budgets, are the very ones over whose reimbursement States have the control. Until 1972, for example, States were required to use the Medicare system for determining the "reasonable cost" of inpatient hospitals reimbursement. Even though this requirement was relaxed, only four States have developed alternative systems because of the state resources required to implement and administer such a system.

Subject to federal evaluation and final approval, States should be allowed to institute alternative methods of reimbursement for institutional providers and fee schedules for noninstitutional providers, consistent with the principle of providing adequate health care. HEW review and revise its current reasonable cost criteria (which States believe are not cost effective) but should not attempt to set fee schedules. The States, if they so choose, should be responsible for developing fee schedules from HEW's revised criteria.

Also subject to federal evaluation and final approval, States should be permitted to establish specific items of allowable costs. For those States not opting to set allowable costs, the federal government should review and recommend changes to existing allowable costs.

Experience has shown that cost containment activities undertaken by only one class of payor have limited impact on the cost of institutional care in the long run, and may also tend to limit access to care for certain types of patients. Nursing homes confronted by Medicaid rates much lower than charges for Medicare or private patients respond by limiting the number of Medicaid patients they will accept. Hospitals can offset lower payments from Medicaid by revenues from other payors, thus incurring actual cost in excess of Medicaid allowable cost.

When aggregate institutional revenues are restricted there is greater potential for real control over the rate of cost increase. With all payors required to conform to similar limits or reimbursable cost, the issue of potentially restricted access to care becomes nonexistent. Both these objectives could be accomplished by prospective budget review and approval programs for hospitals and nursing homes.

Several States have implemented some form of prospective hospital budget review. The Social Security Administration has demonstrated its support for the concept by funding the development and operation of selected state programs. The federal government should adopt an official policy of encouraging such state efforts and providing technical assistance where appropriate.

In redefining the various parameters of allowable cost, reasonable capital costs as well as reasonable operating costs must be considered. This involves explicit recognition of the relationship between the planning activities and provider reimbursement. Thus, the Medicaid and Medicare programs (and other payors) should include as allowable costs only capital, equipment or service charges that are approved by the certificate-of-need process required by PL 93-641.

3. Because of changes in the program and among the states since the Medicaid law was enacted, the present formula ought to be examined by Congress to determine if there are more acceptable methods of deriving the federal financial share.

The present formula used to determine the federal share of Medicaid costs has inherent biases that place undue hardships on some States. The formula uses a multiplier of 45 percent representing the state share and squares the per capita income of the State and the U.S. in the determination of the respective state and federal share.

$$\text{FEDERAL SHARE} = 1 - 45 \frac{(\text{STATE PER CAPITA INCOME})^2}{(\text{U.S. PER CAPITA INCOME})^2}$$

Per capita income used in this formula includes taxes and transfer payments. This causes a bias against States with high taxes and high public assistance transfer payments and caseloads.

There is no allowance in this formula for variations in cost of living from one State to another. Gross per capita income in itself is not a true measure of standard of living. Net disposable income combined with the cost of living might give a truer picture of the relative standard of living.

The formula's provisions for squaring per capita income exaggerate these biases in geometric fashion. This would be endurable within a narrow range of limits, but the present federal share (50 percent minimum up to 83 percent maximum) is so broad that it makes the inherent problems worse.

The squaring provision of the present formula should be removed, and consideration should be given to a State's cost-of-living and public assistance burden. If the multiplier is changed from 45 to 25 percent, even for institutional services, cost participation in the program would be shifted to the federal government.

The present allocation system should be analyzed in view of other alternatives which would distribute available federal dollars more equitably. Most States experience a 50 to 65 percent cost of reimbursing for institutional care to serve less than 20 to 25 percent of eligible persons. A change to allow different determinations of the federal financial share for institutional and noninstitutional providers would help to compensate States for the costs of meeting rigid federal license and certification standards which presently do not allow States to implement certain cost-effective measures.

In any redetermination of federal financial participation, resulting from changes in the formula, States adversely affected should be held harmless for at least two years and under no circumstances should federal financial participation fall below 50 percent.

4. The current system of enforcing fiscal and program accountability within State Medicaid programs should be altered by specifically directing any management fiscal sanctions and eliminating program fiscal sanctions. Increased emphasis should be placed on positive financial incentives for improved state management (as measured by acceptable levels of program performance).

The current myriad of rules, regulations, policies and interpretations in the Medicaid program creates extreme difficulties for state chief executives and administrators striving for effective and efficient management.

The objective of any fiscal sanction should be to correct administrative problems (where proven to exist) or to stimulate additional funding of agency functions to ensure successful performance of required responsibilities. To be effective, any fiscal sanction must penalize the party responsible for an action defined as unacceptable. Without question, passing on of sanctions in the form of a reduction of services for recipients—such as is the case with the Early and Periodic Screening, Diagnosis, and Treatment Program—should be prohibited.

When a problem that may lead to sanctions is first detected in a State's Medicaid program, HEW should immediately notify the Governor, the legislature and

the state agency. Before a sanction of any kind is imposed, a State should have the assurance of a complete adjudicatory/appeals process.

The law should require HEW to accept clear evidence of a State's good faith and should not impose sanctions in such cases. In addition, the federal government should encourage and enable States to adopt measures that would result in major administrative improvements. Positive federal fiscal incentives should be available to States that implement prescribed plans for management improvement.

5. The federal government should finance from general revenues the full financial obligation of copayments and deductibles for medicare recipients also eligible for medicaid.

The present coinsurance and deductible requirements of the Medicare program do not discourage misuse of services since they are not charged directly to the patient eligible for Medicaid and Medicare. The requirements do, however, dislocate and obscure responsibility for payment of the benefits.

These problems are symptomatic of the fact that the Medicare program does not fulfill its original intent to provide medical care for aged and disabled persons. If the government has a social responsibility to provide medical care for the elderly and disabled indigent, it must pay for the cost of that care. The cost of Medicaid covered copayments and deductibles for Medicare patients should be assumed by the federal government in recognition of the problems of providing health care for elderly and disabled poor persons.

One innovative option in administering this process would be for the Medicare program reimburse providers the coinsurance/deductible portion of the bill, for a Medicaid eligible, at the same time the primary portion of the Medicare payment is made. This option would eliminate altogether state involvement, eliminate administrative duplication and allow for a payment transfer from Medicaid to Medicare at the federal level to cover coinsurance/deductible portion for Medicaid eligibles. Under this option providers would be expected to take assignment and annotate on the Medicare claim that the recipient is Medicaid eligible in addition to being eligible for Medicare. The Social Security Administration already has computerized files and systems to include eligibility checks (i.e., Supplementary Insurance Program/SMI) at point of adjudication for Medicare payment.

DELIVERY OF SERVICES

1. In the interest of economy, states should be allowed to determine which health service providers a recipient may choose, if the same quality care can be purchased at a lower cost.

Regardless of how well States manage their Medicaid program, they remain handicapped by their inability to compete in an open market for services on behalf of the poor. To cope with this dilemma and to encourage development of public delivery mechanisms such as well-baby clinics, early screening procedures and immunization programs, the federal prohibition against Medicaid reimbursement to health care providers that generally offer "free" services should be eliminated. If this were done, States would have more latitude in prescribing treatment for certain preventive services at a more economical cost.

One option, which would permit States to utilize the limited Medicaid dollar better, is to redefine the prudent consumer concept vs. the recipient's freedom of choice. States must be allowed in certain cases to determine which health service providers a recipient may use, if the same quality care can be purchased at a lower cost.

2. Federal regulations should be changed to give states wider authority to impose realistic and appropriate sanctions against recipients who willfully overutilize medicaid.

HEW, in cooperation with several effective state programs, should develop a nationwide program to provide for patient management or "lock-in" at state option of those recipients who overutilize services. This is essential to deliver needed health services properly and to conserve scarce fiscal resources.

Further, HEW should develop affirmative policies to deal with recipients who chronically overutilize Medicaid services. These policies might include imposition of copayments on services, outright suspension or elimination from the Medicaid roll.

3. SSI eligibility rules should be amended to prohibit divestiture of personal assets for the purpose of becoming eligible for SSI and Medicaid benefits.

Within existing Social Security regulations it is possible to divest one's total assets and simultaneously become eligible for SSI and Medicaid services. This

situation exacerbates the explosive growth of nursing homes and threatens to drain available fiscal resources of the Medicaid program.

A skilled or intermediate-care patient must relinquish control over all real estate (other than the patient's home), savings accounts, life insurance and stocks and bonds valued at more than \$1,500 to be eligible for participation in the SSI program and Medicaid. Patients may transfer these assets to a relative or friend but may not voluntarily reduce income to become eligible.

The SSI program excludes the value of the home in determining financial eligibility, and as long as States accept Social Security Administration determinations of eligibility, the Medicaid program cannot impose more restrictive requirements or penalties. Previously, a person whose home had an assessed value of \$25,000 or more was not eligible for SSI benefits. However, as of October 20, 1976 the value of the home was totally excluded in determining the resources of SSI applicants (PL 93-569, Section 5).

Such practices encourage families to place an eligible relative in a nursing home at government expense, often without pursuing other arrangements. The divestiture of assets to become eligible serves as an unfortunate enticement to 'warehouse' the elderly and infirm while perpetuating an undesirable breakdown in family responsibility. It is inherently wrong to expect the government to support individuals who, because of a technicality in a law or regulation, can become eligible for programs such as Medicaid one day after divesting themselves of substantial assets.

4. Congress and the administration, in cooperation with the States, must develop a coherent National Policy for Health and Social Care of the Elderly. This policy must endorse use, wherever appropriate, of alternatives to traditional long-term care. Such alternatives should be substantially financed by Federal funds, as institutional care is now financed. If the Federal government continues to encourage the use of traditional institutions to care for elderly persons by providing financial assistance mainly for this type of care, the States will have to seek full Federal assumption of the costs of this care.

Health services to elderly Americans are fragmented and chaotic. The amount and quality of services available to an elderly person will be largely determined by whether that person is eligible for Medicaid in addition to Medicare and by the services and types of care for which Medicaid will pay. A major problem is that Medicaid program limitations often make it impossible for a person to receive needed assistance unless he or she leaves the home and becomes a patient in a long-term care facility. Ironically, this type of care is generally more expensive. As a result, the Medicaid program is needlessly paying for long-term institutional care for many elderly persons who do not need the level of care provided in those facilities but who have no alternative to entering them.

The only way to begin to solve this problem is to make available for all elderly citizens a complete continuum of care including ambulatory services, medical and nonmedical day care, adult foster care, homemaker services, transportation services, long-term care facilities and acute hospital care. States can develop such a continuum only if federal financial assistance for alternative care is available in at least the same proportion as for long-term institutional care. Federal funding, in far greater amount than is now available from any source, particularly Title XX, must be provided—whether through Title XVIII, Title XIX or another existing or new source.

In addition to increasing federal funding for alternative care, a cohesive national policy for health and social care of the elderly should include: (1) Financial incentives, including tax incentives, for families who continue to provide care and shelter for their elderly; (2) increased state latitude in combining funds from federally matched health and social programs to meet special needs of the elderly; (3) federal financial assistance and flexibility for States that experiment with new treatment and care methods believed to be more cost effective and humane; and (4) federally funded research to determine the most appropriate kinds of care for elderly persons in various states of health.

If these types of assistance—particularly the greatly increased federal financial assistance for alternatives to institutional long-term care—are not provided, the expensive, needless and inappropriate mushrooming of institutional long-term care will continue unabated and threaten the entire Medicaid program. States will then have no alternative but to ask the federal government to assume the full cost of long-term care.

5. The law and regulations should be changed to allow States to contract with professional standards review organizations (PSROs) and to review and ap-

prove proposed PSRO policies to ensure that these functions are reasonably accountable to the states.

PSROs, while representing an important and potentially beneficial federal initiative in utilization review, may be doomed to failure unless legitimate state interests are considered.

The fundamental state concern with PSROs is the HEW decision that gave them the authority to approve hospital claims for payment. This ruling permits nongovernmental entities, which practicing physicians control, to obligate State tax dollars without any accountability. States do have to live within allocated budgets. Under the present circumstances PSROs can act independently of the state legislature to increase a State's budget through review activity and establishment of criteria governing medical practices. This situation is unhealthy for state fiscal resources.

State Medicaid programs should continue in their attempts to work cooperatively with the PSROs. The present legal framework, however, fosters a take-it-or-leave-it attitude on the part of some PSROs, which makes a cooperative relationship difficult. The PSRO law should be changed to permit State Medicaid programs to contract with and fund PSROs or other acceptable review organizations on a basis that would permit them to ensure good utilization review but at the same time make them reasonably accountable to the States.

Such functions should be completely federally funded, but state oversight and control of the review standards used by the PSRO or other review function to evaluate claims for payment are so important that partial state payment may be necessary to gain that control.

6. States should be allowed to implement a nominal copayment on mandatory services for categorically eligible Medicaid recipients.

Present federal regulations permit nominal copayments on optional services for categorically eligible Medicaid recipients. Regulations require copayments on all services for medically indigent. There is, however, no provision for copayment on the services classified as mandatory for categorically eligible recipients.

Although the value of copayments as an effective control on utilization in the Medicaid program has not been proven, States ought to be permitted to employ copayment on all aspects of the program including both mandatory and optional services. States should have the ability to impose copayment on individual cases as a disincentive to historic abuse of the program. If they can document and support the need, States should be allowed to choose persons, services and amounts to be subjected to copayments and/or deductibles. The amounts should not penalize eligible recipients or prevent them from obtaining needed medical attention.

The only provision for a State to impose these copayments is under Section 1115 which provides for a waiver by the HEW Secretary for demonstration purposes. With adequate safeguards and effective exemptions, some States believe that nominal copayments system for selective services, with adequate safeguards and effective exemptions, can be instrumental in controlling overutilization by providers and recipients.

Although the categorically eligible recipient is often described as the poorest of the poor, recent experience in the one State where a copayment project was authorized under Section 1115 (copayment imposed on inpatient, outpatient and physician services) did not reveal undue hardship on recipients. If a copayment system is designed properly, with sufficient input from state medical societies and exemption of the most common and inelastic medical services, only the over consumer or the abusive provider would be penalized.

A statutory provision to allow States to use the copayment mechanism, without mandating its use, is essential to help deter overutilization. Too much imposition is placed on the HEW Secretary and States alike to use the authority of Section 1115 for demonstration projects such as the institution of copayments, and its use is subject to legal attacks by vested interest groups. Many States believe that the imposition of copayments, with maximum dollar limitations on both conventional Medicaid and Medicaid/Medicare recipients, can be successfully implemented with minimal administrative inconvenience.

7. States should be allowed to restore family supplementation for Medicaid patients in nursing homes.

Although the provision that allows for family supplementation in skilled and intermediate-care nursing homes has been eliminated from federal regulations, nursing homes are allowed to accept free-will contributions from patients' families. These contributions, if given for nonrestricted purposes, cannot be counted

in the allocation of Medicaid benefits from the State. States believe that this provides a means to circumvent federal regulations prohibiting family supplementation, without any benefits being derived by the federal or state governments. An unscrupulous nursing home operator can make significant profits from these contributions.

Free-will contributions should be controlled. States should be allowed to establish a procedure whereby the State or the nursing home would be allowed to accept voluntary payments from relatives for all or part of the Medicaid rate. These payments, if made to the nursing home, would have to be reported to the State and would serve to reduce the Medicaid reimbursement by the amount of family supplementation. Nursing homes would not be permitted to charge families more than the Medicaid reimbursement. Families, likewise, would have more incentive than at present to keep elder family members at home or to seek an alternative to nursing home care.

Senator TALMADGE. The next witness is Dr. Harold N. Schwinger, chairman, Board of Chancellors, American College of Radiology; accompanied by Dr. Fredric D. Lake, president; J. T. Rutherford, legislative counsel; and Otha W. Linton, director for governmental relations.

Doctor, we are honored to have you appear before our committee and we would be grateful if you would insert your full statement into the record and summarize it in 10 minutes, in the interest of brevity and the multiplicity of witnesses.

STATEMENT OF HAROLD N. SCHWINGER, M.D., CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY, ACCOMPANIED BY FREDRIC D. LAKE, M.D., PRESIDENT; J. T. RUTHERFORD, LEGISLATIVE COUNSEL; AND OTHA W. LINTON, DIRECTOR, GOVERNMENTAL RELATIONS

DR. SCHWINGER. Thank you Mr. Chairman and members of the subcommittee. I am Harold M. Schwinger of Brooklyn, N.Y., chairman of the Board of Chancellors of the American College of Radiology. I am accompanied by Dr. Fredric Lake of Chicago, president of the college and by Otha W. Linton, director of government relations.

My comments on Senate bill 1470 are offered on behalf of the 14,000 physician and physicist members of the college. I express their gratitude to the chairman and members of the Subcommittee on Health for this opportunity.

The American College of Radiology is the major national professional society of physicians who specialize in the uses of X-rays and other forms of energy to produce diagnostic images of patients or who utilize high energy radiation for the treatment of cancers. The college is charged by its members with activities in support of good health care and better radiology. These activities include recommendations about matters of social significance affecting the specialty. Provisions of S. 1470 would have an effect upon the circumstances in which radiologists provide their services to beneficiaries of Federal programs.

As citizens and taxpayers, we recognize the need for the Congress to improve programs by which Federal funds are used to pay for health services. As providers of medical services, we recognize the high costs of the equipment, materials, and support personnel which go into radiology. We recognize further that the successes of modern medicine in prolonging life and maintaining health have worked to increase expenditures. We are sympathetic to the purposes of this bill.

We are grateful to the subcommittee chairman and his staff for opportunities to discuss the substance of S. 1470 during its formative stages. While the advice of doctors is hardly ever taken in full by anyone, anymore, we do appreciate the chairman's kind remarks about our contributions. We also appreciate the subcommittee's responses to some of the problems we have set forth. Our testimony here is limited to elements of S. 1470 which affect us as radiologists.

Some background about the practice of radiology may be useful. I submit for the current record a letter to the chairman in July 1975, from my predecessor, Dr. John M. Dennis. From that letter, I emphasize only that at least two-thirds of radiologists now practice independently in voluntary hospitals on terms which would be compatible with your proposed legislation.

[The letter referred to follows:]

LIMITED ANTI-TRUST EXEMPTION

SECTION 1 POLICY

In the public interest of enabling physicians to establish charges for medical services which have a reasonable relationship to the comparative difficulty, risk and degree of skill required by such services, and to enable federal and state health agencies, fiscal intermediaries and insurance companies to estimate realistically the costs of health care delivery and to determine the reasonableness of particular charges for medical services, it is hereby declared to be the public policy of the United States to permit individual physicians or representative groups of physicians to study, establish or revise codes, indices, standard terminologies and relative value scales for particular medical services.

SECTION 2 DEFINITIONS

1. The term "anti-trust laws" means the Federal Trade Commission act and each statute defined by section 44 of title 15 of the United States Code as "anti-trust laws" and all amendments to such acts and to such statutes and to any other acts in pari materia.

2. The term "representative group of physicians" means a state, regional or national association of physicians described in section 501(c)(3) or (c)(6) of the Internal Revenue Code.

3. It shall not be unlawful under any anti-trust laws for any person or representative group of physicians to create, publish or revise any code, index, standard terminology or relative value scale for particular medical services if such code, index, standard terminology or relative value scale reasonably relates the comparative difficulty, risk and the degree of skill required in rendering such medical services.

AMERICAN COLLEGE OF RADIOLOGY,
Chevy Chase, Md., July 7, 1975.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee, 2227 Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: The following comments are offered on behalf of the 12,000 members of the American College of Radiology who constitute nearly 90 percent of the nation's specialists in the uses of radiologic procedures for the diagnosis and treatment of disease. Our observations are a response to the invitation contained in your June 20 speech in which you announced your intention to introduce legislation which would, among other things, affect the payment by Medicare and Medicaid for the services of radiologists to beneficiaries of those programs.

The principal suggestion will regard to the practice of radiology in hospitals, that radiologists not be compensated by federal programs if they practice under a percentage arrangement, is consistent with policy of this organization adopted in October 1965.

That statement, approved by the College's Board of Chancellors, asserted that: "It is the policy of the American College of Radiology that members of the College shall separate their professional fees from hospital charges and present their own bills to patients."

The full College policy statement contained a paragraph noting that in those institutions where the entire medical staff practiced on a basis other than that of fee-for-service, it would be considered appropriate for the radiologist to share the common status.

Prior to the adoption of that policy, the American College of Radiology had requested the Congress to cover radiology within the Medicare and Medicaid programs as physician service under the Part B section. When this was done in PL 89-97, the College undertook a vigorous campaign to assist radiologists then working under hospital contracts to alter their practice arrangements and bring them into conformity with legal requirements and with the ACR policy stand.

In some areas, the change was relatively quick and easy for most radiologists. In others, it was opposed strongly by hospital groups and certain insurance carriers. Some radiologists lost their appointments because of efforts to separate their professional income from that of their hospital.

In the intervening years, the College as continued its campaign to persuade and assist radiologists to attain an independent, fee-for-service basis of practice in voluntary hospitals. As a professional organization, the College exercised no sanctions against members who disagreed with that policy or who found themselves unable, because of local circumstances, to bring their arrangement into compliance.

In any event, a survey just completed of College members indicates that 64 percent of those practicing in hospitals in which patients are expected to pay for services now bill and collect their own fees. We attach the summary of that survey for your review.

The position of the College favoring fee-for-service was taken in 1965 for several reasons. One was the recognition that the establishment of separate parts A and B of Medicare made it necessary to categorize the professional services of radiologists in one part. The overwhelming preference of radiologists was for a definition as physician services. This would appear to be retained and emphasized within the implementation of the language in your June 20 speech.

A second reason for the College's current policy was the recognition that percentage contracts, the dominant arrangement in 1965, contained the seeds for abuses of several kinds. Many radiologists and hospitals have continued to function with amicable and apparently equitable contracts, with radiologist incomes comparable to those of other physicians. In some instances, there have been abuses which have seemed as obvious to members of the ACR as they may have seemed to federal investigators. In some of these situations, percentage contracts have resulted in unusually high incomes to radiologists. In others, they have resulted in the retention by the hospital of a substantial proportion of funds allegedly charged as the physician's fee and collected by the hospital under its percentage agreement.

Turning to the paragraph of your speech (p S11124) in which you discuss "hospital-based specialists," we would welcome some of the concepts and express caution about others. As might be perceived from our comments above, we do appreciate and accept a premise to compensate radiologists for patient services on a fee-for-service basis. The College and its members would hope that such a fee-for-service would be identical to regulations and protocols for the fee-for-service reimbursement of their physicians for services to patients in Medicare and Medicaid.

We must recognize also that there are situations in which radiologists accept salary arrangements for their services to patients. Thus, it is appropriate for legislation to recognize and accept that such institutional relationships can allow for good radiology services. It has been the College's preference that salary arrangements be applied only in circumstances where patients are not billed for physician or institutional services.

Continuing through your paragraph, we commend your recognition of circumstances in which physicians directly perform services and those in which technical personnel perform certain elements under physician supervision. In radiology, for example, technologists may work with patients to produce the images

from which the radiologist makes his diagnosis. In all instances, the critical diagnostic decisions are made by the radiologist and provided to the patient's attending physician in a written or oral consultation. When the radiologist treats patients, most commonly for some form of cancer, he normally sets up the treatment protocol and supervises each session.

The question of compensating radiologists for administrative and supervisory functions is one which has arisen in good part because current Medicare regulations made it desirable for hospitals to be able to attribute certain professional expenses to departmental costs. In most voluntary community hospitals, radiologists feel that their role in administering radiology departments is akin to that of other chiefs of medical service. Over the past decade, we have observed a trend for hospitals to provide an x-ray department administrator. These x-ray administrators usually are not physicians. They are charged with the logistical management of the department, relieving the physicians to concentrate on providing patient service. Ordinarily, in community hospitals, the radiologists have no source of income other than patient fees and reject any extra payments from the hospital if allowed to practice on a fee-for-service basis.

Conversely, there are large public and academic hospitals in which the chief of radiology and his staff carry burdens of administration, teaching and research which account for significant portions of their time. In such institutions, it is felt proper for there to be arrangements for institutional compensation for such non-patient care.

It should be noted that where a radiologist or group of radiologists hold responsibilities for activities other than patient care, their volume of patient services is diminished proportionately by comparison with a group undertaking only patient services. Thus, we would urge that care be taken to avoid differentiating the basis for compensating the individual patient services of radiologists who also administer or teach or do research from the straightforward fee-for-service to be allowed for their colleagues who spend full time on patient service.

In that same paragraph of your speech, there is a sentence which reads, "No percentage, lease or direct billing arrangements would ordinarily be recognized for Medicare or Medicaid purposes." This sentence introduces two new concepts which should receive serious thought.

Over the years, a relatively small minority of radiologists have practiced in hospitals under a variety of lease arrangements. Some leases were based upon the volume of practice, amounting to an inversion of the percentage contract in which the hospital divided a joint fee with the physician. The majority of leases known to the College represented situations in which the radiologist purchased space, equipment and supportive services from the hospital, usually for a fixed annual fee. The radiologist, in turn, charged patients on much the same basis as he might have billed in a private office not located physically within a hospital.

The lease basis for practice has not been a popular one for hospitals. In some states, attorneys general have ruled that a non-profit institution cannot lease a portion of its facilities without jeopardizing the status of the whole. However, the lease does not necessarily share the same attributes of a percentage contract.

The subsequent phrase in your sentence, "direct billing arrangements," represents what we would hope is a semantic misunderstanding. Within the common usage of that phrase by physicians and health insurers, this refers to the sending of a bill by a physician to a patient for services rendered. We would use the term similarly whether the physician sends it only to the patient or whether he accepts assignment and sends it to a health care insurer. In that context, direct billing is the opposite of arrangements under which a hospital bills for physician services by combining the physician charge with hospital service charges. To us, direct billing and fee-for-service mean the same thing.

If the phrase is meant to prohibit the sending of bills to patients or their insurers by radiologists, then it would negate the fee-for-service basis promised above. If the phrase means that radiologists would be required to accept assignments of benefits for Medicare and Medicaid patients, this would constitute discriminatory treatment and surely would be opposed by those radiologists who refuse assignments and, on principle, by many who accept assignments.

If the phrase could be deleted from further discussions and from legislative language, it would resolve the problem we have suggested and would leave clear your intent to cover radiology services on a fee-for-service basis. If the phrase means something else, we respectfully request further explanation.

In the paragraph in your speech following the one just discussed, we applaud your understanding of the need to cover outpatient diagnostic services in an equitable way to avoid the large movement of patients in covered programs away from physician offices. Such an unchecked movement can only add to the public expenditures involved in expanding hospital facilities and, at the same time, represent an economic waste of private office facilities. We have held that there should be no discrimination in the payment for ambulatory services according to site, i.e., office or hospital outpatient department.

We have written at considerable length about what we perceive as the implications and impact of your words, once translated into legislation. Your legislative intentions are of the utmost concern to the nation's radiologists. They need to be clear enough to avert regulatory distortion. We are grateful for your recognition of our basic desire to continue practice on a fee-for-service basis with Medicare and Medicaid patients. We would hope that you would continue to consult with our legislative counsel, J. T. Rutherford, and with the officers and staff of the College as you develop this legislation.

Sincerely,

JOHN M. DENNIS, M.D.,
Chairman, Board of Chancellors.

Dr. SCHWINGER. We have several observations upon features of the bill which I will express in brief, and I will append more detailed technical comments. For convenience, we will use the same sequence as the items appear in S. 1470.

In section 2, subsection (e), a provision yields the Federal responsibility to States with Federal contracts to establish rate-setting or cost review commissions. There is no requirement therein for any standard approach. Our experience with several of the State commissions now in operation is that their performance lacks the care which the subcommittee is providing in other parts of section 2 to merge the objectives of quality, availability and cost containment. We urge either deletion of subsection (e) or else the imposition of requirements for national standards.

In section 10, the options to accept or refuse assignments are important to doctors for both philosophical and practical reasons. Some radiology groups have had to borrow against Federal program accounts receivable to meet operating costs because of delays in payment and the certainty that medicaid payments, when finally received, will be severely reduced.

In section 10, we applaud the provisions for simplified submission of claims by participating physicians. We are confused about the administrative allowance and we raise detailed questions in our written statement.

In section 12, we can accept for diagnostic and therapeutic radiology the requirements that physician services be "personally performed or personally directed" and "customarily and appropriately done by a physician." However, we are concerned about the specificity of definitions of medical services and procedures elsewhere in that section. Distinctions drawn for payment purposes are difficult to establish in real-life situations. Our admonition is for great care in the handling of this section.

In section 12, further in subparagraphs (b) (2) (G) and in (c) we continue to prefer independent practice over percentage contracts as

a basis for the compensation of radiologists. It has been the policy of the ACR for more than a decade that radiologists should practice in voluntary hospitals on the same independent basis as other physicians. Where all physicians are salaried, then radiologists should share that status. In our written comments, we raise questions about the salary concept.

In expressing a preference for independent radiology practice in hospital departments, we suggested that the seeds of abuse are contained in percentage contracts. Not all percentage arrangements represent an abuse of patients, of hospitals, or of the radiologists involved. Where good faith is observed by radiologists and hospitals, good radiology practice is provided.

In one area, the elimination of percentage contracts may pose a problem which would warrant the subcommittee's indulgence. Some radiologists provide part-time coverage to several rural hospitals scattered over a wide geographical area. Everyone is agreed that this specialty service serves as essential need even though the volume is marginal. These problems can be solved but they may require special handling by program administrators and intermediaries.

In section 15, we appreciate the response of the subcommittee to our earlier requests for relief from current actions against us by Federal agencies on the premise that our preparation and distribution of relative value schedules constituted an unlawful restraint of trade. Since we testified last year, the ACR has accepted a consent decree from the Federal Trade Commission which prohibits us from further involvement with a relative value scale.

In the final analysis, it is the acceptance of any relative value scale by third party payers which determines its usefulness to providers. Since Federal programs are the largest payers for health services, it is appropriate that they review any scales offered by anyone.

The language in section 15 reserves all initiative to the government, allowing professional societies only an opportunity to respond without legal jeopardy.

In our testimony last year on S. 3205, we urged a position which preserves the right of the FTC to investigate possible restraints of trade by the application of relative value scales while also preserving the right of professional societies to act in good faith in their preparation. We still think this is a preferred approach and again enclose possible language to achieve the desired results.

In section 31, we applaud any and all provisions to assist or require Medicaid programs to become more efficient. The delays, inefficiencies and underfunding of many of them seem almost contrived to induce doctors to avoid participation. The college has urged its members to participate in medicaid programs, but we do so with the knowledge that the aggravation often exceeds the income.

In section 40, we note a prohibition on Federal payments under a formula derived from leases of hospital equipment or facilities on a percentage basis. This is consistent with positions of the American College of Radiology. However, some of these existing leases have produced excellent radiology services.

In section 41, we support the provision to cover costs of ambulance transportation for patients between hospitals where specialized facilities are not available in the originating hospitals. Such coverage can

help to avoid duplication of expensive equipment without imposing unintended burdens upon patients.

An additional dimension of the same concept is found in other community and private health facilities freestanding from a hospital. These include the centers for radiation therapy of cancers and sometimes computed tomographic scanners. Most patients served in such community facilities are ambulatory. A small percentage are bedridden and require institutional care in hospitals or extended care facilities is not now covered by the Federal programs.

Radiation therapy may require as many as 40 or more daily visits, and represent significant transportation costs to patients lacking the resources to pay them. We urge extension of the language to cover transportation of patients from institutional care to ambulatory health facilities which serve the entire community.

In section 44, we applaud the intent to prevent the embarrassment of doctors by the publication of erroneous and often misleading information about fees billed for the care of patients covered by Federal programs. Radiology groups are among those embarrassed and harassed by the recent publication of an error-ridden list of physicians billing "large" amounts.

These remarks represent the major themes in our testimony on S. 1470. We submit additional detailed comments in writing and request the inclusion of all our material in the record of the hearing. If any of us now or later can assist the subcommittee further, please request it. We wish the subcommittee well in its efforts.

Senator TALMADGE. Thank you very much.

First, as chairman of this subcommittee, on behalf of this subcommittee and on behalf of the staff I want to thank the American College of Radiology for their very helpful and constructive suggestions in preparing this legislation.

Now, at the bottom of page 9, you refer to institutions where physicians must change to a salary arrangement to be in compliance with S. 1470. While the bill would not permit percentage arrangements, it would not force physicians into salary arrangements, would it?

Dr. SCHWINGER. We can anticipate some situations where if the percentage arrangement were eliminated, the obtaining of independent practice may be near to impossible for various reasons and might, perhaps, leave no alternative but a salary arrangement.

We find this a difficult problem.

Senator TALMADGE. What about the fee-for-service arrangements?

Dr. SCHWINGER. We assume the fee-for-service arrangement to represent independent practice. As I say, there may be some areas where this might be extremely difficult to obtain. There are problems with other third party payers, for example, that might impose serious problems here. Some Blue Cross programs, for example, are rather opposed to independent or fee-for-service kinds of practice and might leave no alternative but for a hospital to make some kind of arrangement with a radiologist and put him on a salary basis.

Senator TALMADGE. In the middle of the paragraph on page 8 you express concern about language in S. 1470 that authorizes the Secretary of HEW to establish limits on medical services, supply and equipment that do not vary in quality from one supply to another.

This simply repeats the language in the present law. There is no change.

Dr. SCHWINGER. Thank you.

Senator TALMADGE. Senator Curtis any questions?

Senator CURTIS. No questions.

Senator TALMADGE. Thank you very much. We appreciate your helpful suggestions and appreciate your continued work with the staff of our subcommittee.

[Additional comments of Dr. Schwinger follow:]

The following comments apply to specific provisions of S 1470.

In Section 2, there is at least the strong possibility of a conflict between the express prohibition in paragraph (b) to amend section 1861 of the act in subparagraph (aa) (2) (C) which excludes from the term "routine operating costs" the "(C) costs of interns residents, and non-administrative physicians" and the subsequent provisions in subsection (e) (2) "the system (created by the state) applies to all revenue sources for hospital services in the state."

Our experience with the several state cost commissions, such as the one in Maryland, already indicates that the commissions are not mindful of the distinctions between physician service and hospital service originally contained in PL 89-97, as amended, and now addressed in detail in sections 10 and 12 of S. 1470. Since the Congress has recognized the separation of physician service on the several occasions, we are reluctant to leave an opening for varieties of departures from this position.

In section 4(c), amendments to section 1122 (d) (B) (i) raise a question of double jeopardy for sponsors of new medical facilities proposals which, of itself, could add time and expense to the process of community approval and thus to the ultimate cost of providing the proposed service. While there is an appeal mechanism to the Department of Health, Education and Welfare, the amount of delay certain to ensue will not contribute to the purpose of this section. We appreciate that the failure of the joint planning agencies to act within 180 days will constitute approval. However, the two houses of Congress have a mechanism which allows them to compromise differences and enact legislation. A more explicit provision for planning agencies would be equally useful.

In section 10 (c) (2), we are puzzled, as we mentioned above, about the application of the \$1 administrative cost-saving allowance offered to some but not all participating physicians. For example, radiologists providing either diagnostic or therapeutic services to hospital patients would be excluded, though a surgeon providing services to the same patients would be covered. A participating radiologist, under the language in subsection (C) performs x-ray examinations in his own office on ambulatory patients who are neither inpatients nor outpatients of a hospital and would thus be eligible for the allowance.

In the official explanation of the bill a different phrase, "... the office of the billing physician." is used and would certainly qualify the office radiologist.

The nature of radiology practice in or out of hospitals lends itself to bulk handling of bills where radiologists are willing and able to accept assignments. We doubt that it is the intent of this section or of its exact language to discourage radiologists from becoming participating physicians. But we must confess our inability even to explain to radiologists with certainty how this provision would affect them or why they have been treated in a discriminatory fashion. We have doubts about the validity of the whole concept and at the very least, we seek further clarification.

In section 11 (a) (1) amending section 1842 (b) (3), we raise a question about the intent of the language in paragraph (C). The phrase in question refers to the meaning of "medical services, supplies, and equipment . . . that . . . do not generally vary significantly in quality from one supplier to another. . ." In many contexts other than legislation, the phrase "medical services" is used as being synonymous with "physician services." We hope this is not the intent here and that we may depend upon those services defined in section 12 as physician services being excluded from the intent and application of paragraph (C).

In section 12 (a) (1) the phrase needing clarification reads, "... or any patient care service unless service (A) is personally performed by or personally directed by a physician for the benefit of the patient and (B) is of such nature

that its performance by a physician is customary and appropriate." In diagnostic radiology, the x-ray, isotopic, ultrasound or thermographic image normally is produced by a trained technologist working under the supervision of the radiologist. The radiologist need not be physically present during the image-making process. However, he must exert continuing supervision over the technologists and he must personally inspect the images produced by them to render a diagnostic opinion. In therapeutic radiology, the radiologist customarily plans a course of treatment and is present during individual treatments. This definition has not been at issue, except very occasionally by the interpretation of a Medicare intermediary. However, it would be appreciated if the legislative history could reflect the understanding stated above.

In paragraph (3), following, we note that the administration of isotopes by a pathologist is included within listings of physician service. This is correct, in our opinion, since pathologists utilize radiosotopes for studies of dynamic body function. However, radiologists and some other physicians also use some of the same isotopes in body imaging procedures. Our point here is to avoid any inadvertent negative inference that only pathologists use isotopes.

Section 12(b)(2) amending section 1842(b)(3A) paragraph (G), and an addition to section 1861 (v) both address the prohibition of the use of a percentage contract between a physician and a hospital as a basis for determining the customary physician charge "... to the extent that the charge exceeds an amount equal to the salary which would reasonably have been paid for the service (together with any additional costs that would have been incurred by the hospital) to the physician performing it if it has been performed in an employment relationship with the hospital ... as the secretary may determine to be appropriate."

Our question relates to the task of the secretary, program administrators and carriers in determining what is "... the salary which reasonably would have been paid for the service." This seems to us to be a mandate for the federal programs to fix or at least to review and approve the levels of physician salaries in those institutions where physicians must change to a salary arrangement to be in compliance with these two subsections. There already exist various bases for salary practice relating to faculty status, civil service and straightforward employment. In theory, at least, institutional charges for physician services to Medicare and Medicaid beneficiaries already are supposed to reflect the incomes and fringe benefits derived by the physicians who perform the services. We think it would be unfortunate for these sections to result in still another federal standard for the income of physicians. Perhaps the legislative history could reflect a limited intent here.

In section 15, we have addressed above our conceptual difficulties with current proposals to allow medical organizations to prepare relative value scales at the initiative of the secretary of Health, Education, and Welfare and subject to his review and approval. If we now presume that the concept as contained in section 15 is to apply, we make the following suggestions about the subcommittee's language.

In paragraph (c), the exemption from consent decrees "by which an association has waived its right to make recommendations concerning fees" perpetuates a point of disagreement between the FTC and the several associations as to whether or not an RVS can be equated exactly with a "recommendation concerning fees." The FTC has contended that the promulgation of a RVS is a *per se* violation. We have argued to the contrary. Our only point here is that the language might be changed to make a distinction.

More cogently, the preparation of RVSs in the past has involved not only the work of expert committees but also a period of testing of their preliminary product by a selected group of radiologic facilities. Such test periods usually have produced refinements and improvements in the final product. If the language now prohibits such reasonable testing, the final product is likely to be inferior and immediately in need of modifications. This could be handled in the legislative history, if the point is well taken.

In section 40(a)(1)(B) we note that there now exists a limited number of leases by which radiologists operate, manage and control radiology departments in hospitals. In some instances, the personnel are employees of the radiologist and the equipment is his property. Some of these instances now involve percentage arrangements or fixed fees per procedure paid to the institution. These arrangements can and will be changed if the bill is enacted. However, it may require some time to disentangle some of these relationships and an appreciation of their complexity in the legislative history would be welcomed.

In section 41, we have already noted the desirability of extending language to cover transportation of patients from hospitals and extended care facilities to free-standing health centers for sophisticated diagnosis and treatment using CT scanners, radiation therapy equipment and other expensive and complex equipment. This should not require any complicated regulations since these are local situations and the carriers are already familiar with them.

In section 44, we again salute the subcommittee for this effort to rectify a situation which has resulted in approbrium and embarrassment for physicians.

These are our comments on S 1470. If there is additional information which the subcommittee seeks which is within our capability to provide, please call upon us. Thank you for this opportunity to comment.

Senator TALMADGE. The next witness is Dr. Tyra Hutchens, president-elect, College of American Pathologists and chairman, Department of Clinical Pathology, University of Oregon Medical School, accompanied by Dr. Jerald R. Schenken, Nebraska Methodist Hospital.

Senator CURTIS. Mr. Chairman?

Senator TALMADGE. Senator Curtis is recognized.

Senator CURTIS. I wish to welcome these distinguished doctors here and I want to say that Dr. Schenken is not a newcomer before this committee. He has given much of his time to improving the practice and public spirit of work in Nebraska Methodist Hospital.

Senator TALMADGE. We are delighted to have you. You come very highly recommended, doctor. If you will insert your full statement into the record and, in the interests of brevity, please summarize it for 10 minutes.

STATEMENT OF TYRA HUTCHENS, M.D., PRESIDENT-ELECT, COLLEGE OF AMERICAN PATHOLOGISTS AND CHAIRMAN, DEPARTMENT OF CLINICAL PATHOLOGY, UNIVERSITY OF OREGON MEDICAL SCHOOL, ACCOMPANIED BY DR. JERALD R. SCHENKEN, NEBRASKA METHODIST HOSPITAL

Dr. HUTCHENS. Mr. Chairman and members of the committee, I am Tyra Hutchens. I am the president-elect of the College of American Pathologists. With me is Dr. Jerald Schenken of Omaha. Dr. Dennis Dorsey, president of the College of American Pathologists has asked me to relay his regrets since illness keeps him from presenting his remarks.

We thank you, Mr. Chairman, for the sincere and complimentary remarks you made about the specialty of pathology both during hearings last year and in a well-received speech delivered at the joint spring meeting of the college and the American Society of Clinical Pathologists.

Mr. Chairman, with the same sense of respect you have expressed for pathology, the college supports the intent of S. 1470; we do, however, have a few concerns.

Prior to the introduction of S. 1470, the college board of governors approved the support of relative value schedules which include a physician's component for each clinical pathology laboratory procedure, as well as other suitable reimbursement mechanisms.

The testimony we offered on S. 3205 was interpreted by some as a defense of the percentage contract as the best mechanism for the reimbursement of hospital-associated pathologists.

I should like to clarify the record. The college was not defending the percentage contract as a reimbursement mechanism superior to all others. We were supporting the concept that a hospital and a physician should be available to them multiple options for payment of pathology services. In our opinion, S. 3205 did not offer acceptable alternatives.

S. 1470 does offer an equitable alternative to percentage contracts for those who wish to avail themselves of the option contained in section 15.

Mr. Chairman, we will now address several specific sections of the bill.

When the subsections of section 12 are viewed collectively, they would appear to restrict the reimbursement options available to hospital-associated pathologists. When studied individually and related to the relative value schedule section of the bill we believe that these seemingly restrictive provisions can be appropriately modified.

Subsection (A) (1) redefines physicians' services as contained in section 1861 (Q) of the Social Security Act. The college is of the opinion that this redefinition would seriously impair the administration of the Act. Defining the term "personally performed by or personally directed" would inevitably lead to a complex maze of regulations.

The college urges that this redefinition of physicians' services be deleted and that the current definition as contained in the Act be retained.

Subsection (A) (2) would add a new paragraph: "(3) pathology services," to section 1861 (q) of the act.

Mr. Chairman, we are pleased with the changes that recognize the performance of autopsies and the supervision, direction, and quality control of the clinical laboratory as professional services. We do, however, have several concerns.

There is actual medical judgment and the potential for medical judgment in every pathology service. The autopsy is medically indispensable. It is the ultimate quality assurance in the practice of medicine. It is an important monitor of the effects of treatment. It must be classified as a physician's service and be fairly compensated under any reimbursement program.

Further, the classification of supervision and quality control as being "customarily performed by nonphysician personnel" is misleading. It recognizes the manual-technical portion of these responsibilities which may be performed by technical personnel, but which are, in reality, only a small part of supervision and quality control. The manual-technical portion is merely the visible result of the policy, procedure and standard setting; evaluation, and action initiative that have been and remain the medical responsibility of the pathologist-director of the laboratory.

In order that the definition of pathology services as contained in this subsection better reflects the fact that there is a physician's component in every clinical pathology laboratory service, we have offered amending language which is included in our written statement.

The college believes that subsection (b) (1) of section 12 provides for a possible solution to problems some hospitals have in obtaining badly needed services. We believe this subsection allows for the lease-type arrangement which the college supports.

It would appear appropriate for the Secretary to approve lease arrangements under circumstances where a lease promotes, among other benefits, the regionalization of certain services, or facilitates the provision of services in locations and settings in which such services would not be economically available.

Turning now to section 15, the college strongly supports its inclusion in S. 1470.

The college long ago recognized the value of appropriate use of relative value schedules. The college's activity in this area was terminated by a consent decree signed by the college with the U.S. Department of Agriculture.

The college welcomes the inclusion of relative value schedules as a basis for establishing a method of reimbursement for physicians. Further, Mr. Chairman, the college maintains that such relative value schedules must contain a physician's component in every clinical pathology laboratory procedure.

A proper and equitable relative value schedule should recognize the following structure: three sets of variables are involved: (1) relative value schedule; (2) the physician's component of the relative value schedule; and (3) the conversion factor—to convert to dollars.

The first variable, the relative value assigned to each item of clinical pathology laboratory service, should reflect the average total effort and expense required to develop the data and prepare a report appropriate for that service. Cost of supplies and equipment and of professional, technical and support effort, all affect the relative value. If a given procedure becomes more complex, the relative value would necessarily rise, and, on the other hand, if it becomes simpler and less expensive, the relative value would decline.

The second variable, the physician's component, is a specified part of the relative value of every item of clinical pathology laboratory service. The physician's component is not a uniform, across-the-board fraction but is determined separately for each item. Thus, it is not a disguised percentage arrangement.

Items having a high physician's component often have a relatively low technical component. Items with a high physician's component requires more professional observation and interpretation by the pathologist. Conversely, items with a low physician's component require less professional observation and interpretation.

Whatever the physician's component, it must include the pathologist's effort in maintaining professional and technical standards. There is no way of foretelling which particular service will require direct attention and special interpretation by the pathologist. This potential need goes beyond his involvement in establishing procedures, evaluating methods, judging the competence of technical personnel, establishing and evaluating quality control, determining abnormal results outside expected norms and other professional services.

Thus, every procedure performed in the Department of Pathology, including the clinical laboratories, involves an actual as well as a possible consultation by the pathologist.

The third variable, the conversion factor, is applied for a given period of time to the current relative value of each item of clinical pathology laboratory service and must be adjusted to reflect general

economic changes, including inflation. Only if inflation were halted and the buying power of the dollar stationary would the conversion factor remain stationary.

This discussion of the relative value schedule with a physicians' component and the earlier discussed lease arrangement in appropriate situations, does not touch upon all types of contractual relations that we support. The college urges multiple approaches to contractual relations between pathologists and institutions. Our discussions of the relative value schedule and the lease arrangement are to point out and support alternatives, not substitutes, for various forms of contractual arrangements.

In an effort to better relate section 15 to section 12, we have offered amending language which is contained in our written statement.

Mr. Chairman, this concludes our comments on S. 1470. When we came before you last year to testify on S. 3205, the college opposed the limitations being placed on contractual relationships between pathologists and hospitals. As you requested we have worked on developing alternatives and specific proposals.

During the past year, there have been fruitful discussions with you, Mr. Chairman, and with the committee staff. We want to continue these cooperative efforts and are ready and willing to assist you at any time.

We thank you for this opportunity to present testimony on S. 1470.

Senator TALMADGE. Thank you very much. I appreciate your thoughtful and constructive statement as well as your expressions of support for a number of provisions in S. 1470.

I want to commend you for presenting what I believe to be a considerably more positive statement than that which was offered last year at the hearings on S. 3205. Your present statement reflects a substantial amount of hard work and effort and give and take.

I want to assure you that we will study your suggestions carefully with a view toward, wherever possible, incorporating those which meet common objectives.

I want to further compliment you and your colleagues for your cooperation and the spirit of cooperation which you have demonstrated with this subcommittee and the subcommittee staff. I think that we have reached substantial agreement now on common objectives.

In referring to your testimony in support of relative value scales, am I correct in my understanding that you are not viewing this merely as an additional reimbursement option but, in fact, your association is agreeing to withdraw its support of percentage contracts in favor of relative value scales?

Dr. HUTCHENS. Yes. The current college policy on this, is that we support the use of appropriate relative value scales as well as other suitable reimbursement mechanisms for pathologists in lieu of percentage arrangements between pathologists and institutions.

Senator TALMADGE. Thank you.

Senator CURTIS?

Senator CURTIS. Thank you, Mr. Chairman.

There are one or two matters here that I would like to have cleared up in my mind. I have not been able to follow all of these hearings in

detail. The chairman of the committee and the ranking minority member of the full committee are ex officio members of all of the subcommittees, but there are too many subcommittees to keep up with the hearings all of the time.

Can you give me sort of an illustration of relative value schedules or scales?

Tell me how this would be arrived at.

Dr. HUTCHENS. May I ask Dr. Schenken to respond to your question, Senator?

Dr. SCHENKEN. Senator, relative value schedules are basically a way to relate one service that a pathologist provides to another, and they are developed in many ways, but basically they are an average of the various efforts and expenses of technical, professional and medical personnel, equipment, services and so on that it takes to provide the final result.

Those are put into dimensionless numbers that only relate to one another. One procedure might have a value of 10, another one 8, another one 12. Therefore, the 12 was more complex, the 8 less complex. They just relate the one study to the other.

Senator TALMADGE. The fee would be based on the relative value thereof?

Dr. SCHENKEN. It will be, and has been in many instances in the past.

Senator TALMADGE. If the Senator would yield, let me see if I can simplify it further.

Suppose lancing a boil had a relative value of 1 and an X-ray had a relative value of, say 20. The X-ray then would be worth 20 times the fee of lancing the boil. Would that be a correct analysis?

Dr. SCHENKEN. If that was the schedule used, that would be an absolutely correct analysis.

Senator TALMADGE. I just took that out of thin air as an assumption in order to try to simplify it in my own mind and simplify it for the record.

Dr. SCHENKEN. If I could amplify on that a little bit, I am glad you brought that up, because it does demonstrate that relative value scales are not limited to pathology but have evolved in all phases of medicine.

Senator TALMADGE. I thank the Senator.

Senator CURTIS. If what we are talking about becomes law, who determines relative value? The physician that performs it, or is that a function that will be exercised by the Government.

Dr. SCHENKEN. We commented on that in our testimony. In the past, relative value scales have been consensus agreements among professional societies and we are certainly and strongly advocating that professional societies have great input into the development of any relative value scales.

Senator CURTIS. The relative value scales, then, are something that has been used in the medical profession in some time in the past; is that right?

Dr. SCHENKEN. For many years. The College of American Pathologists had worked on this for several years, but we are now precluded by our consent decree.

Senator CURTIS. It is an accepted procedure?

Dr. SCHENKEN. Yes.

Senator CURTIS. Within the profession, by practice?

Dr. SCHENKEN. Yes, sir.

Senator CURTIS. I think I know, but clear up for me how a lease type arrangement operates. Does that have something to do with hospitals in small communities, say my own, where the pathologists serve the hospital but none live in the immediate area?

Dr. SCHENKEN. If I might explain our own situation as an example, in our major institution, we have a lease arrangement with a hospital in which we assume 100 percent of the responsibility for all aspects of the provision of pathology services to the patients. We are subject to the same rules and regulations of the medical community as anybody else on our staff, but we have an arrangement with the hospital so that we assume all the responsibilities thereof, rather than the hospital assuming some of those responsibilities.

Senator CURTIS. In other words, patients in the Methodist hospital in Omaha, as far as pathology is concerned, are not dealing with the hospital, but dealing with your center?

Dr. SCHENKEN. Yes, sir.

Senator CURTIS. I observed your point about the definition of physician's services. I have also glanced at the additions proposed to the definition in the bill as it presently printed.

It does strike me that the more complicated and lengthy the term physicians' services become, the greater volume of interpretations, regulations and explanations will be required.

Is that true?

Dr. SCHENKEN. We feel so, yes, sir.

Senator CURTIS. I know that it would be very hard to write an explicit definition for the practice of law. I assume it would be somewhat the same.

I have before me the term "physicians' services" that appears in the present social security law. The term "physicians' services" means "professional services performed by physicians including surgery, consultation, at home, office and institutional calls, but not including services described in subsection (d) (6)."

Do you feel that it would eliminate confusion and problems and a lack of clearness if that definition were enlarged upon as suggested in this present print of the bill? Is that correct?

Dr. SCHENKEN. We believe the present definition in law is preferable.

We also feel, Senator, that the circumstances which we feel caused the drafters of the bill to introduce that change have been eliminated by some of the arrangements provided for in the bill by Senator Talmadge elsewhere in other sections, and therefore, we feel that the elimination of this redefinition will not injure that effort.

Senator CURTIS. That is all I have, Mr. Chairman.

Senator TALMADGE. Senator Dole?

Senator DOLE. No questions.

Senator TALMADGE. Thank you very much, gentlemen. We appreciate your helpful and constructive testimony.

[The prepared statement of Dr. Hutchens follows. Oral testimony continues on p. 358.]

STATEMENT OF TYRO T. HUTCHENS, M.D., PRESIDENT-ELECT OF THE COLLEGE OF
AMERICAN PATHOLOGISTS

SUMMARY

The College of American Pathologists is a medical specialty society representing more than 7,000 physicians.

The College statement offers comment on several sections of the bill with particular emphasis on Sections 12 and 15. In addition, this testimony offers comment on Sections 2, 4, 10, 11, 30, 32, 33, and 44.

The College statement reflects general support for certain Sections of the bill and suggests modification of other Sections. There are a limited number of Sections which it opposes.

The initial portion of the statement is devoted to identifying actions taken by the College to appropriately deal with pathologist's responsibility and pathologist's staffing requirements for institutions. Also included in this discussion is the effort being made by the College to assist in resolving local disagreements on hospital/pathologist compensation.

The major portion of the statement is devoted to comment on Sections 12 and 15.

Section 12

While we are in support of certain provisions of this Section, we have offered language which, in our opinion will better identify the role of the pathologist as a physician. A significant portion of the discussion of this Section outlines the duties and role of a pathologist as a physician.

There is also a discussion of the role the autopsy plays as a medical service and the need for identifying it as a reimbursable service under the provisions of S. 1470. In addition, there is rationale on the need for considering the medical responsibility of the pathologist in regard to services performed by nonphysician personnel in the laboratory as a physician service. We feel they also should be reimbursable as a physician service under the bill. We have offered language changes in subsection (a) (2) of Section 12—" (3) pathology services" which we feel will serve this purpose.

Under subsection (b) (1), we have offered rationale supporting the provision of this subsection which we believe will permit lease arrangements for laboratory services in certain situations.

Subsection (d) (1) concerns us and we have suggested that this provision be dropped from the bill.

Subsection (a) (1) is also a problem area. We feel that the administrative problems which would be created by regulators attempting to define certain conditions in this section would defeat the intent of the section.

Section 15

The College generally supports the majority of the provisions of this section. In our discussion of this section, we point out the role we have played in the development of procedural terminology, not only in the specialty of pathology, but in Medicare.

We also indicate our past experience in the development of Relative Value Schedules.

The major portion of our comment on this section deals with an explanation of Relative Value Schedules and their application to pathology services.

We discuss the three variables which exist in an equitable Relative Value Schedule for pathology services and how they function.

We develop the rationale for a physician component as an integral part of every clinical laboratory procedure. We point out that the physician component is determined separately for each item and therefore is not a disguised percentage agreement.

The statement offers modifying language to subsection (b) which will include physician component as a part of the Relative Value Schedule for hospital-associated pathologists.

The statement points out problems we see developing under the language for subsection (e) and we have offered the suggestion that clarification is needed.

The statement also offers some comment on the following sections:

Section 2

Brief comment supporting the provision for ancillary services not to be included as routine operation costs.

Section 4

We express our concern with the provision providing funds from the Hospital and Medical Insurance Trust Funds for payment of services rendered by State Health Planning Agencies.

Section 11

We go into considerable detail outlining our opposition to the provision of subsection (C) and its possible application to clinical laboratory services.

Section 30

We support the formal recognition of a Health Care Financing Administration in this bill.

Section 32

The statement points out our concern with the use of the "urgent" designation by the Secretary as a mechanism to avoid receiving comments on proposed regulations.

Section 33

The statement offers our opposition to the elimination of the Health Insurance Benefits Advisory Committee.

Section 44

The Statement indicates our support for this section.

STATEMENT

Mr. Chairman and Members of the Committee, I am Tyra T. Hutchens, M.D., President-Elect of the College of American Pathologists. With me is Jerald R. Schenken, M.D., of Omaha, Nebraska.

We welcome the opportunity to appear here today to represent the College of American Pathologists and to present its views on S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

The College is a nonprofit medical specialty organization of physicians with headquarters in Skokie, Illinois. We represent more than 7,000 physicians who practice the medical specialty of pathology. College Fellows are certified by the American Board of Pathology.

Our members practice in hospitals, in independent medical laboratories, in medical schools, in military institutions, and in various facilities of the federal, state and local governments. In addition, our members work in medical laboratory research institutions and in industries producing medical devices and in vitro diagnostic products.

We would like to take this opportunity to thank the Chairman for the sincere and complimentary remarks he made about the specialty of pathology during hearings held last year and in a well received speech that he delivered at the Joint Spring meeting of the College and the American Society of Clinical Pathologists in March of this year.

During the hearings on S. 3205, Mr. Chairman, you said, "your specialty, which I greatly admire—it is the basis of science, and is the basis of medicine . . ." Speaking for our colleagues, we are pleased and honored by these comments.

It is with the same sense of respect that you have expressed for pathology, Mr. Chairman, that the College of American Pathologists supports the intent of S. 1470. S. 1470 is a long and complex bill. Many of its provisions are urgently needed to help contain the spiraling costs of Medicare and Medicaid. Many provisions are innovative and equitable. We do, however, have concerns about specific areas of the bill.

We appreciate the immense effort that you, Committee members, and staff have devoted to a review of the constructive revisions offered in testimony on S. 3205. S. 1470 reflects the benefits of this analytical review.

The College, through its committees and staff, also has spent much time and effort in analyzing this legislation. Much of this effort by the College was di-

rected at finding an appropriate alternative to the reimbursement mechanism offered to hospital-associated physicians in S. 3205.

The introduction of S. 1470 with its recognition of relative value schedules utilizing acceptable procedural terminology systems encouraged the College to consider the relative value schedule approach as an equitable alternative.

Over a year ago, the College convened a Task Force of 35 pathologists, broadly representative of the various practice modes of pathology, to develop constructive proposals for changes in S. 3205. This Task Force has continued its work and has considered S. 1740. It has developed some proposals and recommendations which have been approved by our Council on Government Relations and Board of Governors and are reflected in the statement that we are presenting today.

The official College policy statement provides for:

(a) A study of local review mechanisms to resolve disagreements in hospital pathologist contractual relations, with implementation of such mechanisms as soon as a satisfactory format has been developed;

(b) A study of the professional responsibilities of pathologists and pathologists' staffing requirements for institutions, using existing data as well as additional, readily available data to validate the results of the study.

In addition, the College policy statement:

(a) Reaffirms existing College policy that all pathologists' services are physician's services and are an integral part of the practice of medicine;

(b) Supports the definition of physicians' services that is contained in the Social Security Act (Section 1861(q));

(c) Continues College support of multiple approaches to contractual relations between pathologists and institutions;

(d) Reaffirms College support of relative value scales that include suitable professional components for all pathologist's services as a satisfactory mechanism for reimbursement, and further, such relative value scales should include pathologist's services when performing autopsies; when providing quality control in the pathology department; when providing professional direction and supervision of departments of pathology; and when participating in educational programs related to patient services;

(e) Supports the use of appropriate relative value scales as well as other suitable reimbursement mechanisms for pathologists, in lieu of percentage agreements between pathologists and institutions.

The second portion of this policy statement relates directly to the reimbursement of pathologists. In effect, it states that the College supports the use of relative value schedules which include physician's component for each clinical pathology, laboratory procedure as well as other suitable reimbursement mechanisms.

Mr. Chairman, those engaged in the delivery of clinical laboratory services have recently received unfavorable publicity in the media and have come under scrutiny by committees of the Congress. Much of this publicity has been related to fraud. If one looks closely at the information presented, it is clear that fraud usually appears incident to the delivery of clinical laboratory services in so-called "Medicaid Mills". Fraud apparently has not occurred with any frequency in hospital laboratories or pathologist-directed independent laboratories. Because of our concern that perhaps pathologists were involved in the so-called "Medicaid Mills", we have requested information from the Senate Select Committee on Aging about pathologist(s) who may have been involved in fraudulent activity.

There has also been publicity about seemingly inappropriate reimbursement of individual pathologists relative to the services provided by them.

In our opinion, the College has responded in a positive way by designating committees and working groups of the College to identify the problems and work on solutions without interfering with the many fine relationships which presently exist between pathologists and institutions throughout the United States.

The first portion of the College policy statement referred to earlier in this testimony mentions this committee activity.

One activity involves a study of pathologist's work patterns and performance. Because pathology is a broad and varied discipline, it is difficult to categorize and quantitate activities in which pathologists spend most of their time. The reasons for this are:

1. No two pathologists carry out their practice in exactly the same way.
 2. The demand for pathology services varies greatly from one day to the next and from one week to the next. This variation is related more to the *type* than to the amount of service.

3. Laboratories in different communities and in different hospitals have strikingly different workloads and patterns.

4. Individual pathologists have varying productivity capabilities.

5. Individual pathologists have different areas of professional expertise. This is related to subspecialization.

The College will continue this effort to develop appropriate criteria for pathologist's performance and criteria for determining a pathologist's reimbursement based on his performance.

Another active College effort is the study of local, regional, and state review mechanisms that can be used to resolve disputes, complaints, and problems relative to pathologists and pathologists' compensation. We know that these problems exist. However, because some problems have considerable community importance and may be sensitive in nature, the College believes that voluntary mechanisms should be established if they do not presently exist and where they do exist, be strengthened when necessary.

Essentially, we are talking about a "counseling service". The principal features of this service would be: (1) availability to any person or organization legitimately concerned about conflict in a hospital-pathologist relationship; (2) voluntary participation by the involved parties; (3) credibility; and (4) multiple mechanisms to choose from which would function at either the local, state, or regional level.

The College is developing materials and guidelines for use in these counseling and dispute-resolving activities.

It is hoped that cooperation can be developed between the College and other appropriate organizations which will help in effective implementation. This might include boards of trustees of hospitals, joint conference committees of medical staffs, county and state medical societies, medical specialty societies, local, regional, state hospital associations, and appropriate government agencies.

Mr. Chairman, in our testimony presented to this committee on S. 3205 in July of 1976 we went into a lengthy discussion on the need for multiple contractual options being available to the hospital-associated pathologist.

The testimony we offered was interpreted in some circles as being a defense for the percentage contract as the best mechanism for the reimbursement of hospital-associated pathologists' services.

I would like to clarify the record. The College was not defending the percentage contract as a reimbursement mechanism to all superior others. We were supporting the concept that a hospital and a physician should have available to them multiple options for payment related to the delivery of pathology services. In our opinion, S. 3205 did not offer acceptable alternatives.

Mr. Chairman, the College in its Contractual Relationships Manual has attempted to offer pathologists guidance as to the advantages and disadvantages of different contracts without mandating any particular arrangement. In this manual the percentage contract is offered as an alternative to an item-by-item billing mechanism. The language of the manual recommends that the percentage be related to a specific fee schedule as a deterrent to excessive increases in the pathologist's income due to inflation alone.

The manual further cautions that in an inflationary period laboratory charges may increase and that in this situation the pathologist's income will increase out of proportion to time and effort dedicated to patient services.

I offer these comments only to illustrate the long-time recognition by the College of the problems inherent in a percentage agreement and our effort to point out these problems to pathologists.

It is our opinion that S. 1470 does offer an equitable alternative to percentage contracts to be utilized by those pathologists and hospitals who wish to avail themselves of the option contained in Section 15.

Mr. Chairman, I would now like to address specific sections of the bill.

Section 12—Hospital-Associated Physicians

Mr. Chairman, the College has carefully reviewed this section of the bill. This review has been conducted in an effort to find an equitable alternative to the present language in—

Subsection (a) (1)—Definition of physician services ;

Subsection (a) (2)—“(3) pathology services”;

Subsection (b) (1)—Amendments to Section 1861(s) of the present law ;

Subsection (b) (2)—Amendments to Section 1842(b) (3A) of the present

law; and

Subsection (c)—Amendments to Section 1861(v) of the present law.

When the subsections of Section 12 are viewed collectively, they would appear to restrict and limit reimbursement options available to hospital-associated pathologists. When studied individually and related to the Relative Value Schedule section of the bill (Section 15) we believe that these overly restrictive provisions can be appropriately modified.

Mr. Chairman, we will discuss these subsections in the order in which they appear in the bill.

Subsection (a) (1)—redefinition of physician services

Mr. Chairman, the language of this subsection has been carefully studied by the College members. This review was aimed at determining how this redefinition might affect the administration of the act and how it would affect the quality of services provided to patients.

The College is of the opinion that the redefinition as it appears in subsection (a) (1) would seriously impair the administration of the act. Defining the term “personally performed by or personally directed” would inevitably lead to a complex maze of regulations. For example, we wonder how these regulations would define “personally directed” in an equitable fashion assuring optimal patient care. We also believe that inevitably, complex regulations would result in so much red tape as to impair the quality of physician's services provided to patients.

Mr. Chairman, we would urge that this redefinition of physicians' services be deleted and that the current definition as contained in 1861(q) of the Social Security Act be retained.

Subsection (a) (2)—“(3) pathology services”

Much of the testimony which we presented last year on S. 3205 and which is a part of those hearings, described what a pathologist is and what he does. We will not repeat this in detail today. However, a brief summary of those views appears appropriate.

Pathology is that specialty in the practice of medicine that deals with the causes and consequences of disease and with the diagnosis, treatment, and prognosis of patients, using primarily laboratory methods from the biological, chemical, and physical sciences.

As the basic science most closely related to clinical medicine, the clinical discipline closest to basic science, pathology is often called the bridge between basic sciences and clinical medicine. It links the basic sciences of anatomy, biochemistry, genetics, microbiology, physiology, and pharmacology with such clinical disciplines as internal medicine, surgery, obstetrics and gynecology, and pediatrics.

The day-to-day functions of a physician/pathologist are broad and varied:

1. Patient care—providing laboratory data and clinical pathological consultation essential for the assessment, diagnosis, and treatment and management of disease.

2. Education—teaching of new generations of medical students, future pathologists, other physicians, nurses, technologists, and other allied health personnel.

3. Research—expanding man's basic knowledge about the nature of disease and the possibilities of applying this knowledge to prevention and cure.

As these functions are normally provided concurrently during the pathologist's daily practice, they are usually inseparable.

Because pathology is a large and complex field, its practice is usually subclassified by the following two major categories:

Anatomic pathology, which deals with the gross and microscopic structural changes caused in tissues by disease; and

Clinical pathology, which is concerned with the functional changes produced by disease as reflected in blood, urine, other body fluids, and tissue.

The close interrelationships between these areas consolidate the specialty in practice.

Mr. Chiarman, we are pleased with the changes in subsection (a) (2) which recognize the performance of autopsies and the supervision, direction, and quality control of the clinical laboratory as professional services.

There is actual medical judgment and the potential for medical judgment in every pathology service.

For example, the autopsy is medically indispensable. It is the ultimate quality assurance in the practice of medicine. It is an important monitor of the effects of treatment. It must not be classified as nonmedical, and it must be fairly compensated under any reimbursement program. The autopsy presents an excellent mechanism for evaluating the reliability, appropriateness, and benefit of the many clinical pathology tests which have been performed. Peer review, infection control, death review, utilization review, medical audit—none can be performed effectively without autopsies performed by pathologists.

Further, the classification of supervision and quality control as being "customarily performed by nonphysician personnel" recognizes only a small part (the manual-technical portion) of the responsibilities often performed personally by technical personnel without recognizing that the policy and procedure setting, standardization, evaluation, and action initiation must be the medical responsibility of the pathologist director of the laboratory. This is especially critical for the hospital laboratory.

In order that the definition of pathology services as contained in this section better reflect the fact that there is a physician's component in every clinical laboratory service, we would urge the following amendment:

Strike the present language contained in Section 12 (a) (2), "(3), Pathology services" and insert the following:

"(3) Pathology services shall be considered physicians' services where the physician performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. Exercise of this medical judgment includes operating room and clinical consultations, the interpretation of the significance of examination of any material or data derived from a human being, the aspiration or removal of marrow or other materials, the administration of test materials or isotopes, the performance of autopsies, and services performed in carrying out medical responsibilities for supervision, quality control, and the other aspects of a clinical laboratory's operations."

It is our understanding however, that although these are physician's services, some of them would not be reimbursable as physician's services under Part B of Medicare. We do not believe that elimination of these services as Part B items is appropriate. They should be recognized as physician's services under Part B in the same way as other physician's services.

Subsection (b) (1)

Another method of compensation which the College supports in a variety of circumstances is a lease-type arrangement. Certain lease arrangements are the most effective means of providing laboratory services to numerous hospitals in this country. In our view, subsection (b) (1) of Section 12 recognizes the problems that some hospitals have in obtaining badly needed services. We believe this subsection allows for the lease-type arrangement which the College supports. For the benefit of those who may not understand the need for this type of arrangement, the following points may be of help:

1. *Regionalization.*—Lease contracts enhance the opportunity to reduce costs and charges by regionalization of specialized pathology services within groups of institutions and/or pathologists, thereby facilitating cost accounting and minimizing economic barriers which might exist. Cost containment through sharing of capital expenditures, such as large Autoanalyzers, computers, and other sophisticated equipment, may be easily and appropriately implemented thereby reducing the need for a large number of this expensive equipment often costing hundreds of thousands of dollars.

2. *Small institutions.*—Lease arrangements, especially when facilitated by regional cooperative agreements, will accommodate the needs for provision of services to small hospitals. A significant percentage of the seven thousand acute care hospitals in the United States have fewer than one hundred beds. These are in desperate need of clinical pathology consultation and specialized services which can be provided in many instances most appropriately and economically on a lease-based, fee-for-service arrangement. Development of transportation,

communication, and courier mechanisms can bring the patients in small hospitals comprehensive pathology services of high quality.

3. *Fee-for-Service*.—This system provides a mechanism for compensation of the pathologist on the basis of a fee-for-service and clearly identifies that fee to the patient as a fee for the total clinical pathology laboratory service provided. The pathologist is clearly identified to the public and must justify this fee to third party payors including government fiscal intermediaries.

4. *Clerical and Billing Costs*.—These costs can be minimized if the volume of the clinical pathology laboratory develops to a significant degree. This is often facilitated by cooperative regional arrangements combining laboratory facilities and services on a shared or cooperative basis among several institutions, some of which may be small. With appropriate medical managerial skills, an additional opportunity is offered to develop cost-saving mechanisms within the administrative section of the laboratory, for the patient's benefit. The day of the pathologist without these managerial skills is over because of the number and variety of skills necessary to render prompt and efficient service 24 hours per day.

5. *Taxes*.—The entire pathology department is maintained on local, state, and federal tax rolls. The amount varies but does contribute to the local tax rolls. The amount varies but does contribute to the local economy by paying appropriate sales and/or property taxes as do other independent practitioners of medicine.

6. *Hospital Control*.—It is often stated that hospitals lack appropriate controls under lease arrangements. This does not actually occur in practice. Pathologists are physicians on the medical staff with specified privileges, responsibilities, and duties. Quality and quantity of the medical services provided are under constant internal surveillance. In addition, the administration, board of trustees, and staff physicians can all act as "patient advocates". This is not a myth; it operates as a fact. In addition, a review with the patient, doctor, or hospital is promptly set in motion if the patient feels that the pathology fees are inappropriate for the services provided. Personnel policies and procedures can and should be made compatible with those of the hospital. Finally, contractual arrangements can be varied as appropriate locally to provide for adequate control without interfering with professional judgment.

These points touch upon the many advantages of a lease arrangement. It would appear appropriate for the Secretary to approve lease type arrangements under circumstances where a lease promotes regionalization of certain services; facilitates the availability of a wide variety of medical and nonmedical professional personnel; assists a hospital in maintaining the total fees for clinical pathology laboratory services well within the guidelines established for a region; or facilitates provision of services in locations and settings for which such services are not available or would not be available under alternative methods of arrangement and/or compensation. In addition, provisions should be included for continuation of presently existing lease arrangements which have been deemed acceptable by local medical staffs, boards of trustees, intermediaries and carriers, and others and would thereby be deemed "ordinarily" acceptable under the general guidelines. It would seem inappropriate for the Secretary of DHEW to become involved in receiving requests for permission to provide pathology laboratory services under a lease arrangement and act on such requests on an individual basis. The arrangements are best and most appropriately made locally. Many areas of local professional and fiscal review presently exist to ensure the appropriateness of such arrangements.

The College fully offers its assistance to this committee and the Secretary in the development of guidelines, if required, for the appropriate application of the lease-type arrangement.

Subsection (d) (1)

In subsection (d) (1) of Section 12, it appears that the established procedure for reimbursing inpatient pathology services at the 100% payment level is being restricted to those physicians who accept assignment. We must oppose this restriction for the same reasons that prompted the Congress to amend the Medicare law in 1967 so as to clearly provide for 100% reimbursement for pathology and radiology services to hospital inpatients, provided by physicians specializing in pathology and radiology. (See Senate Finance Committee report #744, 1967).

The problem is presently dramatized in those areas where fiscal intermediaries have arbitrarily reintroduced 80% reimbursement limits for clinical pathology

laboratory services provided to hospital inpatients by referral to an off-premises reference laboratory while continuing 100% reimbursement for work performed in the hospital's own laboratory. If the Committee so desires, we will provide details on this situation.

This arbitrary interpretation of Medicare regulations is especially discriminatory against patients in small hospitals. We urge that this practice be eliminated.

Mr. Chairman, we recommend the removal of subsection (d) (1).

Section 15—Use of approved relative value schedule

Mr. Chairman, in your speech before our group in Miami in March of this year, you said:

"One approach that I am actively pursuing is the use of relative value scales. I am aware of the activities of both the Department of Justice and the Federal Trade Commission in questioning the use of relative value scales. Nonetheless, such scales have been employed for years as a means of determining relative effort and time required in undertaking one service as compared with another.

To my mind, the issue is whether the relative values attached to the different services are reasonable—and not whether we should have relative value scales. I have therefore, instructed our staff to work on a suitable amendment for inclusion in my bill specifically sanctioning, in law, properly-established relative scales. I would welcome the suggestions and comments of the College of American Pathologists in this work."

We wholeheartedly support this statement and offer our assistance in developing such a system of properly established relative value schedules for clinical pathology laboratory services.

The College strongly supports the inclusion of Section 15 in S. 1470. The College has long been involved in the development of nomenclature for use in the clinical pathology laboratory. With the ever-increasing advancement and complexities in the provision of quality laboratory services, the need for a systematized, standard nomenclature increases. The College has taken the lead in developing such a system for the laboratory with the development of a Systematized Nomenclature for Pathology, (SNOP). This system has been in use since 1965. The success of SNOP has led to the on-going development of a Systematized Nomenclature of Medicine, (SNOMed). We will be pleased to offer our assistance to the Secretary in the development of procedural terminology for pathology.

The College long ago recognized the value of appropriate use of relative value schedules. As far back as 1961, the College developed a relative value schedule for pathologists' services and updated this schedule several times. Its use by the College was terminated by a consent decree signed by the College with the U.S. Department of Justice.

The College welcomes the inclusion of relative value schedules as a basis for establishing a method of reimbursement for physicians. Further, Mr. Chairman, the College maintains that such relative value schedules must contain a physician's component in every clinical pathology laboratory procedure.

A proper and equitable relative value schedule should recognize the following structure:

Three sets of variables are involved: (1) relative value schedule, (2) the physician's component of the relative value schedule and (3) the conversion factor (to convert to dollars).

The first variable, the relative value assigned to each item of clinical pathology laboratory service, should reflect the average total effort and expense required to develop the data and prepare a report appropriate for that service. Cost of supplies and equipment and of professional, technical, and support effort, all affect the relative value. If a given procedure becomes more complex, the relative value would necessarily rise, and, on the other hand, if it becomes simpler and less expensive, the relative value would decline.

The second variable, physician's component, is a specified part of the relative value of every item of clinical pathology laboratory service. The physician's component is not a uniform, "across-the-board" fraction but is determined separately for each item. Thus, it is not a disguised percentage arrangement. Items having a high physician's component often have a relatively low technical component. Items with a high physician's component almost invariably require more professional observation and interpretation by the pathologist. Conversely, items with a low physician's component require less professional observation and interpretation. Whatever the physician's component, it must include the pathologist's

effort in maintaining professional and technical standards. Even in the case of services with a low physician's component, there is no way of foretelling which particular service will require direct attention and special interpretation by the pathologist beyond his involvement in establishing procedures, evaluating methods, judging the competence of technical personnel, correcting procedures, establishing and evaluating quality control, determining abnormal results outside expected norms, and other professional services. Thus, every procedure performed in the department of pathology, including the clinical laboratories, involves an actual as well as a possible consultation by the pathologist. We have discussed this in greater detail in our testimony on S. 3205.

The third variable, the conversion factor, is applied for a given period of time to the current relative value of each item of clinical pathology laboratory service and must be adjusted to reflect general economic changes, including inflation. Only if inflation were halted and the buying power of the dollar stationary, would the conversion factor remain stationary.

In short, Mr. Chairman, we strongly support the use of a relative schedule with an appropriate physician's component as a basis for an equitable method of reimbursement for pathologists.

This discussion of the relative value schedule with a physician's component and the earlier discussed lease-type arrangement in appropriate situations does not touch upon all types of contractual relations that we support. As stated in the action of the College Board of Governors, the College urges multiple approaches to contractual relations between pathologists and institutions. Our discussions of the relative value schedule and the lease arrangement are to point out and support alternatives, not substitutes for various forms of contractual arrangements.

In an effort to better relate Section 15 to Section 12, we would urge the following addition to the language of Section 15:

Amend Section 15, subsection (b) by inserting a new sentence following the sentence ending with the word "terms" so that the subsection would read:

"(b) Upon development of a proposed system of procedural terminology and its approval by the Secretary of Health, Education and Welfare, it shall be published in the Federal Register. Interested parties shall have not less than six months in which to comment on the proposed system and to recommend relative values to the Secretary for the procedures and services designated by the terms. *In the instance of hospital-associated pathologists' procedures and services, such relative value schedules shall include physician components for each clinical pathology laboratory procedure.* Comments and proposals shall be supported by information and documentation specified by the Secretary."

In addition, the College would suggest some modification to subsection (e) of Section 15. This subsection seems to give broad discretionary powers to the Secretary. As we interpret the wording, the Secretary may review and modify terminology and relative value schedules without any requirement to consult with groups affected by such actions.

We would suggest that the bill or the Committee Report give guidance to the Secretary as to a reasonable definition of "periodically" and that this review and modification should not take place without proper consultation with and input from representatives of the medical specialties directly involved.

Further, more positive acknowledgment of the accomplishments in the areas of procedural terminology by medical specialty organizations should be included in the legislation. The Secretary should be required to consider these efforts in mechanisms outlined for the acceptance and approval of procedural terminology and relative value schedules.

We would now like to turn our attention to several other sections of the bill.

Section 2—Criteria for determining reasonable cost of hospital services

The College recognizes that the issue of reimbursement of hospital must be addressed. We do not believe it is our function here today to comment on this broad and complicated issue. If our understanding is correct, laboratory services would fall under "ancillary service costs" and thereby be excluded from the definition of routine operating costs. We believe this to be appropriate.

Section 4—Federal participation in hospital capital expenditures

We are concerned with Section 4 of S. 1470. We question the wisdom of providing for expenses incurred by planning agencies from the Federal Hospital Insurance Trust Fund and funds in the Federal Supplementary Medical Insur-

ance Trust Fund. These trust funds presently have tremendous demands upon them in meeting the rising cost of providing service to Medicare patients. To divert funds to pay for health planning activities does not appear to be a timely proposal. The health planning process is very much in a developmental phase and the College fears that much money would be lost due to the confusion that the health planning process is presently experiencing.

Another point of concern is obtaining approval of the local designated planning agency for capital expenditures in excess of \$100,000 as a condition for Medicare and Medicaid reimbursement for such costs. Clinical laboratory equipment needed for routine operation today is very expensive and that cost cannot be expected to lessen. To set a review "trigger" of \$100,000 is unreasonable to us. We would suggest a substantial increase of that \$100,000 figure or the removal of a dollar figure in this section.

Section 10—Agreements by physicians to accept assignments

The College believes that the wording of this section creates a discrimination against hospital-based physicians, pathologists in particular. Subsections (c) (2) (B) & (C) specifically excludes pathologists who direct bill from benefits of the administrative cost savings allowance.

We would recommend that these discriminatory provisions be eliminated, or if that is not possible, be modified so that there might be some aggregate figure per bill below which no cost savings allowance would be appropriate.

Section 11—Criteria for determining reasonable charge for physicians' services

Subsections (a) (1), (C) and (E) provide for the establishment of a lowest charge level for medical supplies, services, and equipment, and prevailing charge levels for each state.

Because of many factors involved in determining the cost of a clinical pathology laboratory service, it is inappropriate, if not impossible, to apply a lowest charge level to such a service. In some instances, the utilization of lowest charge levels for reimbursement may be appropriate for medical supplies and equipment such as hospital beds and wheel chairs. To group clinical pathology laboratory services with manufactured medical supply items ignores the varying cost components present in the delivery of laboratory services.

Laboratory services may vary in quality from one laboratory to another in a given locality. Determining the cost of such services is a very complex issue. If this determination is to be meaningful, one must evaluate all the elements of cost associated with the testing process and consider the cost and value of what happens as a result of that testing. The availability of services must be considered. In each element of cost, there must be recognition given to the professional input of medical direction, supervision and responsibility provided at all levels by the pathologists.

What elements of cost would be considered under the lowest charge level? Does the lowest charge level refer to only the actual physical performance of the test, or does it include the entire service provided, beginning with the test order and ending with the return of the final results to the patient's chart? The services required by patients vary considerably depending on the patient's location and medical condition. Costs of collection, preparation of tests and transmittal of results are costs which may or may not be included. For the same type of tests, the fee charged may legitimately vary depending on whether 9 a.m. to 5 p.m. weekday or 24-hour emergency availability is required. If the lowest charge level is to apply only to the physical performance of the test, it would not take into account other critical components of a procedure and is therefore incomplete. If the lowest charge level includes the whole spectrum of providing the laboratory service, then this section will create an administrative nightmare for carriers trying to develop the multiple fee profiles required.

It is our belief that the implementation of a lowest charge level system of reimbursement for laboratory services could result in the following:

Subjecting laboratory services to price comparison would be misleading. There are many factors such as availability, specificity, sensitivity, pickup service, reporting, overhead expenses, and others which must be considered. Clinical pathology laboratory services are not numbers generated by machines.

The lowest charge level wrongly places emphasis on procedures that can be automated rather than procedures that are appropriate. Test procedures are done by varying methods under varying situations. Some tests may be automated in one situation and not in another.

The administration of a lowest charge level method of reimbursement will be hopelessly complex.

Charge differentials would have to be developed depending on the specimen sources (arterial, capillary, venous), time of day, location of patient (rural, urban, suburban), patient's age, general availability of services and other factors.

The philosophy behind our discussion of concerns over a lowest charge level is in many ways appropriate to the development of prevailing charge levels for each State. Such prevailing fee development must take into account the location and circumstances under which the service is provided. Was it inpatient or outpatient? Was it routine or emergency? Did the laboratory obtain the specimens? Was it a preprocessed specimen?

We urge careful consideration of these points in developing prevailing charge levels for each state or its economic region. We also recommend elimination of laboratory services from the lowest charge concept.

Section 30—Establishment of Health Care Financing Administration

To quote you, Mr. Chairman, in your introductory remarks in the Senate on S. 1470:

"Although I am most proud that the new administration followed my proposals, I am most apprehensive that in implementing this reorganization, the aims of the original proposals may be lost.

I had proposed this reorganization in order to collapse duplicative functions within the existing agencies and to establish clear lines of command and authority.

From the latest information available to us, it seems as if the new health care agency, rather than collapsing overlapping positions and clarifying lines of authority, may do the opposite and establish a new bureaucratic superstructure as a haven for displaced bureaucrats."

The College shares your concern. We believe it appropriate that the establishment of a Health Care Financing Administration and an Office of Assistant Secretary for Health Care Financing be included in this legislation.

Section 32—Regulations of the Secretary

The College understands the need for prompt action on certain proposed regulations. However, there are no safeguards built into this section to preclude the Secretary using the sixty-day "urgent" designation to avoid receiving and reviewing comments in opposition to such proposed regulations.

The due process for the public in allowing them to comment on proposed regulations in a manner that is appropriate should be provided. The development of a position by any health care organization would be jeopardized by unrealistic rigid limitation of the amount of time in which comment may be made. We recommend this rigid limitation be eliminated from the bill.

Section 33—Repeal of section 1867

Mr. Chairman, HIBAC presently is the only advisory body available for presentation of views on the administration of Medicare and other health financing programs. We believe that to terminate HIBAC without the establishment of an appropriate form would not be in the public interest.

Section 44—Disclosure of aggregate payments to physicians

The College strongly supports this provision which would prevent the release of names of physicians who have been paid large amounts from treating Medicare patients.

The harm and embarrassment caused by inaccurate releases has been obvious.

Even accurate releases can be misinterpreted, e.g., billing for an entire pathology group under one individual's name may be done for simplicity. A technically accurate but highly misleading figure is thus listed against one physician on any list released.

CONCLUSION

Mr. Chairman, this concludes our comments on S. 1470. When we came before you last year to testify on S. 3205, the College opposed the limitations which were placed on contractual relationships between pathologists and hospitals. As you requested, we have worked on developing alternatives and specific proposals. We have worked to create mechanisms for preventing abuses of reimbursement mechanisms for pathologists. We have worked to help others better understand

the complexities of the pathologist's role in the clinical laboratory. We have also worked to help pathologists understand the complexities of government concerns over the cost of health and medical services.

The College has taken action to support the use of relative value schedules including a physician's component. We will work with the Committee and the Secretary to develop an equitable system.

We support the intent of S. 1470 to contain the increasing costs of Federal health care programs. We pledge our support in providing high quality clinical pathology laboratory services to the public at a reasonable cost to the taxpayer.

During the past year, there have been fruitful opportunities to confer with you, Mr. Chairman, and with the Committee staff. We want to continue these cooperative efforts and are ready and willing to assist you at any time.

We thank you for this opportunity to present testimony on S. 1470.

The next witness is Ruth E. Ecklund, president, American Association of Nurse Anesthetists, accompanied by Ronald F. Caulk, president-elect; J. Martin Stone, executive director; and Kenneth Williamson, Washington consultant.

We are delighted to have you. If you would submit your entire statement for the record and, in the interests of time, summarize it in 10 minutes.

STATEMENT OF RUTH E. ECKLUND, PRESIDENT, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS; ACCOMPANIED BY RONALD F. CAULK, PRESIDENT-ELECT; J. MARTIN STONE, EXECUTIVE DIRECTOR; AND KENNETH WILLIAMSON, WASHINGTON CONSULTANT

Ms. ECKLUND. Thank you, Mr. Chairman.

Mr. Chairman, I am Ruth E. Ecklund, CRNA, president of the American Association of Nurse Anesthetists and chief nurse anesthetists, Family Hospital, Milwaukee, Wis. Accompanying me are Ronald F. Caulk, CRNA, who is president-elect of the association; J. Martin Stone, who is executive director of the association; and Kenneth Williamson, who is the Washington consultant for the association. We appear here today in behalf of the association.

Mr. Chairman, the next two paragraphs of my statement I will not read, in the interests of time. It sets forth the purposes of our association.

On the bottom of page 1 and top of page 2, we have indicated the percent of anesthetics provided by nurse anesthetists in hospitals of various sizes which shows that nurse anesthetists provided a substantial portion of the total of the anesthesia care in the large medical centers where the most complicated surgery is performed as well as in smaller hospitals.

In the interests of time, I will not read the following two paragraphs. We wish at this time to direct our testimony to S. 1470 and we will limit our comments and recommendations to those provisions of the bill which deal with anesthesia services as a part of section 12 entitled Hospital—Associated Physicians, starting on page 31 of the bill.

In July of last year we appeared before the committee and discussed S. 3205. We made a number of recommendations which we felt would improve the bill and its administration, which gave some recognition to the major role of nurse anesthetists and which, most importantly, were essential to protect the public and assure quality

of anesthesia services. We are, of course, quite disappointed that none of our recommendations are incorporated in S. 1470.

We believe the same weaknesses exist in S. 1470 that were part of last year's bill. In various ways, our reading of the bill suggests that insufficient attention is directed to the effect of the bill's provisions upon patient care or the quality of that care. Thus, S. 1470 shows no concern for half the patients receiving surgery because it contains nothing pertaining to those professionals who provide the anesthesia to these patients, the nurse anesthetists. Once again, the bill does absolutely nothing to bring a degree of fair treatment and equity to nurse anesthetists. In fact, it totally ignores them.

On pages 3 and 4, Roman numerals I through VII, we have set forth recommended changes in the bill which we believe are essential to protect patients and insure quality care. I will not read them. We have attached an appendix labeled exhibit A that has the specific language that incorporates our recommended changes.

I direct your attention to the bottom of page 4 where we will discuss equity and fairness.

Mr. Chairman, over the past several years, we have met with representatives of the Social Security Administration. We have also spent a great amount of time in discussions with the staff of the House Ways and Means Committee and the Senate Finance Committee and we have given testimony at hearings before both committees. In all of this, we have tried to provide some understanding of the role of the nurse anesthetist and of what we believe to be a simple right for them to be accorded fairness and equity under the law. Notwithstanding all of these efforts, we were advised that it was unlikely that our appeals for fairness and equity and removal of discrimination would be entertained unless we provided specific legislative language. Therefore, we turned to a highly skilled and experienced draftsman who performed such activities for the Congress for a number of years and he drafted the specific recommendations for amending titles XVIII and XIX of the Social Security Act which we wish to present.

I will not read the specific language for amending the Social Security Act that appear on pages 5 and 6.

On the bottom of page 6, I wish to read the explanation of the amendments.

In general, the amendments recommended do three things. First, they permit hospitals to charge separately under medicare and medicaid for the services of nurse anesthetists who are employees of the hospitals. Second, they permit nurse anesthetists who are not employees of the hospitals where they perform their services to bill directly for their services under part B and under medicaid.

Third, the amendment states that the charge for the services of a nurse anesthetist shall be deemed to be reasonable if that charge does not exceed the percentage of the charge for those services which could have been made by a board certified anesthesiologist physician determined by the Secretary to be reasonable.

Mr. Chairman, I will not read the discussion of the recommended amendments that follow on pages 6 and 7, except to point out a significant omission that appears on page 7. In the discussion of section 5, line 3, the word "not" should appear immediately before the words "hospital employees."

Our recommendations set forth above were drafted in such form that they could be presented as a separate bill. We hope, however, Mr. Chairman, that the language will be included as a part of S. 1470. Thus, the bill would deal with anesthesiologists and their role; and an additional section will deal with nurse anesthetists and their role.

President Carter and his administration have expressed their great concern for the increasing costs of health services. The Congress has also done so and, in part at least, S. 1470 is directed to these problems. We believe our recommended amendments pertaining to nurse anesthetists are very much in keeping with the purpose of President Carter and of the Congress and would result in substantial savings to the public.

In our opinion, recommendations for amendments to the Social Security Act as they relate to reimbursement for anesthesia services should accomplish three objectives. Specifically:

One, decrease total expenditures spent on anesthesia services by the Government, or other third party payers;

Two, provide incentives to the providers of anesthesia to be as efficient as possible; that is, the lowest cost without adversely affecting quality;

Three, improve the equity of the various parties involved.

We believe that the proposal which we have presented accomplishes these objectives. However, we recognize that reimbursement of nurse anesthetists on the basis of charges poses certain questions. For example, a suggestion has been made that nurse anesthetists might move away from salaried employment to self-employment if these amendments were adopted.

This is unlikely to occur because of the many advantages identified with an employed status, that is, job security, fringe benefits, malpractice insurance coverage provided by the hospital, et cetera.

Second, the overall economic status to the hospital employed nurse anesthetists will probably improve and thereby provide little incentive to move away from an employed status. Because of these factors, we believe our recommended amendments may well encourage more nurse anesthetists to go from a self-employed to a hospital based arrangement.

On the bottom of pages 8 and 9, we have given a specific example, which I again will not read, of the kinds of reduction of total cost which would result through the adoption of our proposed amendments.

Mr. Chairman, I direct your attention to the middle of page 9, the sentence beginning with "in this factual example." The word "salary" should be replaced with the word "income."

We do believe that the proposal satisfies our three objectives, decreasing total expenditures, maintaining quality and improving equity.

On the second half of page 9, we discuss the self-employed nurse anesthetist. Our previous testimony and statements discussed the role of the self-employed nurse anesthetists who are called upon by hospitals, or members of the surgical staff of hospitals. This occurs where no anesthesiologist is available and where nurse anesthetists are not employed by the hospital, or when additional anesthesiologists or nurse anesthetists are needed. The present medicare and medicaid laws provide the rankest sort of discrimination against these health profes-

sionals Under the law, a physician can bill the Government directly for his services as an individual practitioner whereas a nurse anesthetist who is fully qualified and renders the services is prohibited from doing so.

A letter from the chairman of this committee to Ms. Iris Berry, CRNA and president, Georgia State Association, of Nurse Anesthetists dated January 13, 1977, contained the following assurances to correct this situation. "You will be pleased to know that, as one result of the Finance Committee's hearing on S. 3205, I have decided to make appropriate changes in the revised bill so as to allow for an equitable reimbursement mechanism for those nurse anesthetists who practice their profession independent of hospital employment. I believe that this will help resolve a substantial portion of the problems you raised."

Our reading of the bill does not indicate that any improvement has been made.

Mr. Chairman, in the following paragraph on page 10 we have again stated our belief that a national study of all anesthetic services is greatly needed. We attempted to bring about such a study. I wish to read our specific recommendations which apply there.

Though our recommendations here relate to the economic aspects of the services provided by nurse anesthetists, we have a major and continuing concern for the quality of these services. Substantial efforts are being directed to the education of nurse anesthetists. Working with the U.S. Office of Education, our council on accreditation is striving to continually improve the education provided. We have also developed a set of standards for nurse anesthetist practice.

We are continuing extensive programs of information and education related to new procedures, new techniques and the like, and we have in public testimony, urged the development of a national study of the quality of all anesthesia services, which we believe is badly needed.

Our council on practice has had correspondence and discussions with the Department of HEW and following preliminary efforts by a committee of knowledgeable persons, they met with representatives of five sections of HEW who have a concern for anesthesia services to discuss the possible assistance of the Department in financing such a study.

Unfortunately, they have made little progress with HEW. It has seemed to us inasmuch as the public is expending more than \$2 billion a year on anesthesia services and the service is provided in such life and death situations that the Government would have a major interest in seeing that a thorough study of the quality of anesthesia services is made. We urge that this committee and the Congress in its report on this bill direct the appropriate persons in HEW to see that such a nationwide study is undertaken without further delay.

We have provided a summary statement of our testimony citing specific recommendations, which we have presented. We appreciate this opportunity to once again bring our views to you and we would be pleased to be of any possible assistance to the committee.

We ask that our complete statement be made a part of the record of these hearings.

Senator TALMADGE. Without objection, that will be done.

I am somewhat surprised by your testimony. I recall when we met and I got staff working on this and we had a meeting with your organization I thought that we had reached agreement in what would be incorporated in the bill.

Mr. Constantine, would you relate what happened?

Mr. CONSTANTINE. Since medicare's enactment, there have been a host of groups—dieticians, licensed practical nurses, physical therapists, physician extenders, social workers, who want fee-for-service.

The general attitude has been that more fee-for-service would generally be inflationary to the cost of the programs. Although physicians are paid on a fee-for-service basis, that was an historic fact when medicare was enacted. In almost all other cases, health professionals were a part of hospitals or other organized settings such as clinics.

The nurse anesthetists came in and discussed certain problems with us at a dinner meeting some 2 months ago which Mr. Kern of our staff also attended. We told them at the outset that we did not believe the staff could recommend to the committee fee-for-service for nurse anesthetists.

That was not the purpose of the meeting, we were told. They described four problems to us. One was alleged exploitation by some anesthesiologists who use nurse anesthetists extensively to provide the anesthesia service and then the anesthesiologist bills and collect for the nurse's work. The leadership of the Society for Anesthesiology recommended specific services, included in the bill, which an anesthesiologist must perform to earn his fee and which would avoid that exploitation.

The recommendations were incorporated verbatim. We believed, and recommended to the committee, that they were fair and quite explicit. As a matter of fact, the original recommendations were stronger than we thought were necessary.

The second concern was that in larger hospitals they suggested that nurse anesthetists be members of the hospital staff. That was preferable to being employed by the anesthesiologist. The bill does contain a provision toward that end. That is, in a hospital which is large enough to have full-time nurse anesthetists where the anesthesiologist earns a fee and uses a nurse anesthetist to assist him who is employed by him, he is required to pay her out of his fee.

If he uses a hospital staff anesthetist, he still earns his fee but the hospital pays the nurse and medicare and medicaid would pick that up as a routine hospital cost. Obviously there is an incentive for the nurse anesthetist to be employed by the hospital.

Another suggestion they made is that the committee should put something in as to how much a nurse anesthetist should be paid by the hospital. We suggested that that was merely a matter for negotiation, just as other nurses negotiate with hospitals.

A third issue was the circuit-riding nurse anesthetist who serves rural hospitals and hospitals too small to retain an anesthesiologist and where there is no other source of service. We asked what the problem was there. They described two problems. One was, that in many instances the hospitals were being billed by the nurse anesthetists for services and medicare will recognize that as a reasonable charge to

the hospital as an arrangement with others. We do pay for that now, but the hospitals were taking substantial percentages of those amounts for the nurse anesthetist's service for billing and collection purposes.

We believe that practice is contrary to present law and we have asked the Bureau of Health Insurance to look into the matter. We thought that that might be double dipping, where the hospital takes not only 30 percent of the nurse anesthetist's charge but probably includes its own administrative costs as a hospital expense where the Government pays for it again.

That is being looked at right now.

The other related aspect that they described to us was where the surgeon who calls in the nurse anesthetist, bills for the anesthesia service and then pays the anesthetist whatever proportion of that amount he chooses to pay. We suggested to them that that was probably violative of an amendment that the Finance Committee put in the tax laws in 1969 relating to fee splitting.

That is, if he billed \$300 of which \$100 was for the nurse anesthetist and he gives her \$50 and he rendered no service, in that regard, he may not deduct the \$50 as an expense. The entire \$300 is income to him.

Those were the principal problems which we understood and which we discussed with the nurse anesthetists. We were not involved in a discussion of fee-for-service for the services of nurse anesthetists. We were involved in a discussion of avoiding exploitation, both in the rural area, the smaller hospital area, and by anesthesiologists and in relation to their concern that they be members of hospital staffs.

Senator TALMADGE. Senator Dole?

Senator DOLE. I have listened to the testimony and also to Mr. Constantine. I am sort of lost.

How are we going to save any money? Two billion dollars is a great deal of money. I read your statement at the bottom of page 8 and the top of page 9. How much money are we going to save if we adopt the suggestions you made?

You only have one example there. You say it is a factual example.

Ms. ECKLUND. Yes, it is, sir.

Mr. WILLIAMSON. We had an economist, Senator, make a projection from specific examples and he estimated the area of \$200 to \$300 million would not be an unfair or unlikely savings that could result from the approach that has been recommended here. This would come about because there would be equity and efficiency since the fee would be determined by the Secretary, and based undoubtedly, in relationship to the training and experience of the individuals and not whether they happen to be a physician or a nurse, which in itself could make considerable difference.

I think that it would make it possible for the services to be revenue-producing to hospitals and therefore, an incentive to them to be concerned with who performs the anesthetic in a way that they are not now. The services performed and billed by anesthesiologists would be increasingly performed by nurse anesthetists and would be billed at a much lower rate.

I think in the situation where the nurse anesthetists perform six or eight procedures and are paid a salary, but the anesthesiologist bills his full fee, that would change appreciably. We believe all of these

things together and the incentive to the hospital would result in very substantial savings, Senator.

Senator DOLE. Are you in essential agreement with the statement of Mr. Constantine? Do you have any different view?

Mr. CAULK. If a physician has utilized the services of a nurse anesthetist in a small community hospital; and if the physician cannot get something for collecting the fee for the nurse anesthetist then he refuses to collect and the nurse anesthetist has no alternative for being paid, because they cannot bill themselves. They have no way to be paid for their service.

Mr. WILLIAMSON. I think at a meeting you can come away with different understandings of what you agree to, but in our reading of the bill, we do not think it helps the individual nurse practitioner and I think apparently Jay thinks it does.

As a matter of fact, the words added to the bill, "who need not be his employee," would likely result in the Government's paying twice for one procedure. They would have to pay the anesthesiologist and then the hospital would be entitled to bill a second time for the services of the nurse anesthetist. We do not see those words as helping the freelance nurse anesthetist at all, unless there is some other understanding, which we do not have, of those words.

Senator TALMADGE. I would like Mr. Constantine to comment on that.

Mr. CONSTANTINE. The point there is the nurse anesthetist who is a salaried staff member is paid on a cost basis, fringe benefits and other costs, not on a given procedure. The incentives in the bill are obviously for the anesthesiologist to use a staff nurse and, in most cases, in discussing the matter with the leadership of anesthesiology, they agreed.

If the same fee is paid for the procedure and in one instance the anesthesiologist has to pay the employee out of his fee, and in the other instance he does not have a pay, where we will wind up will be for him in most cases—for large hospitals, not the smaller hospital, not talking about that—that they will start to use, obviously, staff nurses. The economic incentives—if that needs clarification——

Mr. WILLIAMSON. I think that is what we are saying. We think it needs clarification. We do not think it will accomplish that purpose.

Senator TALMADGE. Would you work with the staff and try to clarify that?

Do you have any questions, Senator Curtis?

Senator CURTIS. No.

Senator TALMADGE. Senator Dole?

Senator DOLE. Aside from that, you are in essential agreement with what Mr. Constantine has started this morning. You did not address the one issue of fee-for-service? That was not the purpose of the meeting, even though you raised it in this testimony.

Of course, we will consider it.

Aside from that, there is a basic understanding?

Mr. WILLIAMSON. No, I would not say so, Senator—no. The area that Mr. Constantine touched upon, the free-lance nurse anesthetist, we do not think is clarified and the ability of hospitals to bill on a charge basis is not clarified.

We do not think the economics for the nurse anesthetist are improved at all. We thought, from our conversations, that they would be.

Senator DOLE. You can still pursue that and try to clarify those points. It would certainly be helpful to the members of the committee.

Mr. WILLIAMSON. Yes.

Senator TALMADGE. Thank you very much. We appreciate your contribution to our deliberations.

[The prepared statement of Ms. Ecklund follows:]

STATEMENT OF RUTH E. ECKLUND, PRESIDENT OF THE AMERICAN ASSOCIATION OF
NURSE ANESTHETISTS

SUMMARY

This statement constitutes a summary of our presentation to the Committee concerning S. 1470. We shall limit our remarks to those provisions of the Bill dealing with anesthesia services for which we have a special competency and particular interest. Secondly, we are submitting for consideration amendments to the Social Security Act which would authorize the payment of charges by Nurse Anesthetists under Title XVIII and XIX.

Purpose: To address and make recommendations to effect change which would bring about equity and fairness and the removal of discrimination in the treatment and reimbursement of Nurse Anesthetists for services rendered. The present language of S. 1470 may be interpreted in such a way so as to hinder the delivery of quality anesthesia care to the American people.

Basis: Certified Registered Nurse Anesthetists administer nearly half of all anesthesia in the United States.

Sixty percent of the hospitals in the United States are without the services of an American trained Anesthesiologist.

S. 1470 does nothing to change the existing and very unfair treatment accorded Nurse Anesthetists under Medicare/Medicaid.

With the interest of the Administration and Congress in cost containment, it would appear to be advantageous to look to those areas where the full potential of health professionals can be realized without altering quality so as to reduce the cost of health care to Government and the consumer.

The annual cost of anesthesia services is in excess of \$2 billion. Changes achieved can result in savings of several hundred million dollars. The recommendations we are making can result in such savings and, therefore, are fully in the public's interest.

Recommendations

I. We recommend, therefore, that on page 31 line 18 the word "only" be inserted between the words "physician" and "where".

II. We recommend, therefore, that the language for activity (B) appearing on line 21 of page 31 be amended to read "writing an anesthetic management care plan".

III. We recommend, therefore, that the language of activity (C) appearing on line 22 of page 31 be amended to read as follows: "personal participation in the induction, management, and emergence and assuring that a qualified Nurse Anesthetist perform any of the procedures which the physician does not personally perform".

IV. We recommend, therefore, that the words appearing on line 25 on page 31 "who need not be his employee" be deleted.

V. We recommend, therefore, that the language appearing on lines 3-4 of page 32 be amended to read as follows: "remain physically available during the course of anesthesia administration".

VI. We recommend, therefore, that the language on lines 8-20 of page 32 be made more specific so as not to diminish the quality assurances which the Bill proposes and impede the administration of the Law.

VII. We recommend, therefore, that on line 13 of page 32 the words "another individual" be deleted and the words "a qualified Nurse Anesthetist" be inserted.

VIII. We recommend, therefore, that amendments to the Social Security Act submitted in this Statement be considered so as to provide equity and fairness to Nurse Anesthetists and remove existing discrimination.

IX. We recommend, therefore, that the Law be amended to enable the self-employed Nurse Anesthetist to bill directly for services in much the same way as other individual practitioners.

X. We recommend, therefore, that this Committee direct the appropriate persons in H.E.W. to see that a nationwide study on the quality of anesthesia is undertaken without further delay.

We appreciate this opportunity to present our views to you and would be pleased to be of all possible assistance in working with the Committee and its staff to attain the very laudable goals set forth by the Chairman of the Committee in the statement he made upon the introduction of the Bill.

Mr. Chairman, I am Ruh E. Ecklund, CRNA, President of the American Association of Nurse Anesthetists and Chief Nurse Anesthetist, Family Hospital, Milwaukee, Wisconsin. Accompanying me are Ronald F. Caulk, CRNA, who is President-Elect of the Association, J. Martin Stone, who is Executive Director of the Association, and Kenneth Williamson, who is the Washington Consultant for the Association. We appear here today in behalf of the Association.

The Association is a professional organization whose membership is comprised of Certified Registered Nurse Anesthetists (CRNA's), practitioners and educators who are engaged in anesthesia practice. The Association's two major goals, both of which serve the public interest, are, first, to promote the continued existence of quality education in the schools of nurse anesthesia and, secondly, to enhance and further develop the clinical skills of individual Nurse Anesthetists to provide quality care for patients. This testimony suggests the Association is also directing its activities toward obtaining greater equity and degree of fairness for Nurse Anesthetists which does not exist in the present Law.

Nurse Anesthetists are a major group in the delivery of anesthesia services. There are over 16,000 practicing CRNA's and there are approximately 10,840 Anesthesiologists (M.D.'s). The largest percentage of anesthetics administered to patients in the United States is provided by Nurse Anesthetists. Approximately 16,500,000 surgical procedures were performed in 1974, and CRNA's provided the anesthesia services in 48.5 percent of these cases. In 40 percent of the hospitals in the United States a Nurse Anesthetist is the sole provider of the anesthesia services, working as a member of the operating team along with the surgeon in performing a highly essential service to hospital patients.

In hospitals of less than 50 beds Nurse Anesthetists administered 67 percent of the anesthetics, in hospitals with from 50 to 90 beds 65 percent of the anesthetics, in hospitals with 100 to 250 beds they administered 50.4 percent of the anesthetics, and in hospitals of over 250 beds they administered 42.5 percent of the anesthetics. Thus, Nurse Anesthetists provided a substantial portion of the total of the anesthesia care in the large medical centers where the most complicated surgery is performed as well as in smaller hospitals.

Approximately 100,000 patients are receiving care each day in hospitals of less than 100 beds. A substantial number of these patients, of course, do have surgical procedures requiring anesthesia services. As we have indicated, the anesthesia required by these patients is in the main provided by Nurse Anesthetists and it is to the Nurse Anesthetist that the surgeon looks for responsible competency in providing this phase of an operation.

CRNA's are officially recognized by the U.S. Department of Education, the Federation of Specialty Nursing Organizations and the American Nurses' Association, the American Society of Anesthesiologists, the American Hospital Association, the American College of Surgeons and the Joint Commission on Accreditation of Hospitals. The performance of CRNA's and the quality of the services they render is attested by their widespread use in university medical centers, community hospitals, the veterans administration and armed services. CRNA's by their education are fully prepared and competent to provide anesthesia services utilizing the various anesthetic agents. Attached for your information is a copy of the Standards for Nurse Anesthesia Practice which gives a good indication of the preparation of the Certified Registered Nurse Anesthetist and the guidelines by which they practice. We have previously provided various supportive materials to the members of the Committee.

We wish at this time to direct our testimony to S. 1470 and we will limit our comments and recommendations to those provisions of the Bill which deal with anesthesia services as a part of section 12 entitled "Hospital-Associated Physicians" starting on page 31 of the Bill.

In July of last year, we appeared before the Committee and discussed S. 3205. We made a number of recommendations which we felt would improve the Bill and its administration, which gave some recognition to the major role of Nurse Anesthetists and which, most importantly, were essential to protect the public and assure quality of anesthesia services. We are, of course, quite disappointed

that none of our recommendations are incorporated in S. 1470. Thus, we believe the same weaknesses exist in S. 1470 that were part of last year's Bill. In various ways, our reading of the Bill suggests that insufficient attention is directed to the effect of the Bill's provisions upon patient care or the quality of that care. Thus, S. 1470 shows no concern for half the patients receiving surgery because it contains nothing pertaining to those professionals who provide the anesthesia to these patients, the Nurse Anesthetists. Once again, the Bill does absolutely nothing to bring a degree of fair treatment and equity to Nurse Anesthetists. In fact, it totally ignores them. Therefore, we wish to present our specific comments and recommendations.

We recommend that:

I. On line 18 of page 31 the word "only" be inserted between the words "physician" and "where" as it appeared in the Bill introduced last year. We believe that the deletion of the word "only" substantially changes the requirements to be considered in stipulating those services to be "personally performed" by a physician and is not in the public's best interest.

II. The language for activity (B) appearing on line 21 of page 31, be amended to read "writing an anesthetic management care plan." The present language which requires the writing of a prescription would seriously harm the orderly process of providing anesthesia because Nurse Anesthetists cannot write prescriptions, whereas they can and do formulate management care plans.

III. The language of activity (C) appearing on line 22 of page 31 should be amended to read as follows: "personal participation in the induction, management, and emergence and assuring that a qualified nurse anesthetist perform any of the procedures which the physician does not personally perform;"

This change would assure the continued presence of a qualified physician or nurse anesthetist who would be responsible for the anesthetic throughout its full course. The language of the Bill appears to be intended to assure the continued presence of a qualified person who is requested by the physician to be responsible for the anesthetic throughout the remainder of its course. The words qualified "individual" do not provide such assurance and therefore, we have recommended that the Bill stipulate that a "qualified nurse anesthetist" perform any of the procedures which the physician does not personally perform. This is absolutely essential to protect patients and assure quality of care which the present language of the Bill may deny.

IV. That the words "who need not be in his employee" which appear on line 25 of page 31 be deleted. Our reading and attempts to find a meaning of the words left us confused. We do not believe that they serve any desired purpose, nor are they in any way beneficial to patients. In contrast to the purpose of the Bill, these words will likely result in the government paying twice for the anesthesia, i.e., the physician could collect his fee and in addition the hospital could bill the government for the costs of the Nurse Anesthetist. We believe also that words "less demanding" in this same sentence are most demeaning and misleading. Our concern is for the patients and there are no minor or less important aspects of their anesthetic.

V. The language of lines three and four on page 32 should be amended to read as follows: "remaining physically available during the course of anesthesia administration". Just as activity (E) requires the physician to remain "physically available", such physical availability is absolutely essential throughout the course of the anesthetic.

VI. The language of S. 1470 commencing on line 8 of page 32 with the words "provided however", substantially diminishes the quality assurances which the Bill proposes in (Activity A through F) and vitiates what we believe is surely a central purpose of the Bill, that of assuring quality of patient care. The language of this Bill commencing on line 8 and continuing through line 20 on page 32 is most unclear as to its purpose. It is unclear as to whether the language is intended to refer to reimbursement procedures for physicians or is also intended to include quality of practice. We believe this uncertainty will result in making the administration of the law very difficult. The language may read as permitting a physician to be responsible in whole or in part for the anesthetic being administered to six different patients simultaneously only one of which he is required personally to administer. This is simply not good practice and certainly it is not in the best interest of the patient. We believe the language needs to be much more specific.

VII. The words "another individual" appearing in line 13 on page 32 be deleted and the words "a qualified Nurse Anesthetist" be inserted. Such activities as those enumerated in (A)-(F) of the Bill are in a great many instances performed by the Nurse Anesthetist. In nearly half of all the anesthetics administered, an Anesthesiologist is neither present nor available.

For ease of reading, we have appended to this testimony a statement incorporating the recommended changes in the language in Section 12 of the Bill (Appendix A).

EQUITY & FAIRNESS FOR NURSE ANESTHETISTS

Mr. Chairman, over the past several years, we have met with representatives of the Social Security Administration. We have also spent a great amount of time in discussion with the staff of the House Ways and Means Committee and the Senate Finance Committee and we have given testimony at hearings before both committees. In all of this, we have tried to provide some understanding of the role of the Nurse Anesthetists and of what we believe to be a simple right for them to be accorded fairness and equity under the Law. Notwithstanding all of these efforts, we were advised that it was unlikely that our appeals for fairness and equity and removal of discrimination would be entertained unless we provided specific legislative language. Therefore, we turned to a highly skilled and experienced draftsman who performed such activities for the Congress for a number of years and he drafted the specific recommendations for amending Titles XVIII & XIX of the Social Security Act which we wish to present.

It is recommended that the Social Security Act be amended to authorize the payment of charges by Nurse Anesthetists under Title XVIII and XIX of that Act:

Section 1814(b) of the Social Security Act is amended by inserting immediately below paragraph (2) thereof the following: "Notwithstanding paragraph (1) of this subsection, a hospital which uses the services of a nurse anesthetist who is its employee may be reimbursed for such service on the basis of a fee schedule established by such hospital which provides for payment to the hospital for such services in amounts not exceeding the reasonable charge therefor as set forth in the last sentence of Section 1842(b)(3)."

Sec. 2. The last paragraph of Section 1812(b)(3) of the Social Security Act is amended by adding at the end thereof the following new sentence: "The charge for the services of a nurse anesthetist shall be deemed to be reasonable if such charge does not exceed the percentage of the charge for those services which could have been made by a physician who is a Board Certified Anesthesiologist which the Secretary determines is reasonable."

Sec. 3. Section 1861(b) of the Social Security Act is amended (1) by striking out "and" at the end of paragraph (4), (2) by striking out the period at the end of paragraph (5) and inserting in lieu thereof"; and", and (3) by inserting immediately below paragraph (5) the following: "(5A) the service of a nurse anesthetist who is not an employee of the hospital."

Sec. 4 (a) Section 1861 (s) of the Social Security Act is amended (1) by striking out "and" at the end of paragraph (8), (2) by striking out the period at the end of paragraph (9) and inserting in lieu thereof"; and", (3) by redesignating paragraphs (10) and (11) as paragraphs (11) and (12), respectively, and (4) by adding below paragraph (9) the following:

"(10) the services of a nurse anesthetist who is not an employee of the hospital in which the services are performed."

(b) Section 1864(a) of the Social Security Act is amended by striking out "(10) and (11)" and inserting in lieu thereof "(11) and (12)."

Sec. 5. Section 1902(a) of the Social Security Act is amended (1) by striking out "and" at the end of paragraph (35), (2) by striking out the period at the end of paragraph (36) and inserting in lieu thereof "; and", (3) by inserting immediately below paragraph (36) the following:

"(37) Provide with respect to the services of a nurse anesthetist employed by a hospital that the hospital may bill separately and be reimbursed for such services in amounts not more than the reasonable charge for such services as determined under the last sentence of Section 1842(b)(3). and provide with respect to the services of a nurse anesthetist not employed by the hospital, that such nurse anesthetist may bill separately and be reimbursed for such services in amounts not more than the reasonable charge for such services as determined under the last sentence of section 1842(b)(3).

Sec. 6 (a) Section 1905(a) of the Social Security Act is amended (1) by striking out "and" at the end of paragraph (16) (2) by inserting "and" immediately after the semicolon at the end of paragraph (17) (and (3) by inserting immediately below paragraph (17) the following: "(18) the services of nurse anesthetists;"

(b) (1) Section 1902(a) (13) (B), and Section 1902(a) (13) (i) of such Act are each amended by inserting", and in clause (18)," immediately after "(5)."

(2) Section 1902(a) (14) (i) of such Act is amended by inserting", and in clause (18)," immediately after "(7)."

EXPLANATION OF THE ABOVE AMENDMENTS

In general, the amendments recommended do three things. First, they permit hospitals to charge separately under Medicare and Medicaid for the services of nurse anesthetists who are employees of the hospitals. Second, they permit nurse anesthetists who are not employees of the hospitals where they perform their services to bill directly for their services under Part B and under Medicaid. Third, the amendment states that the charge for the services does not exceed the percentage of the charge for those services which could have been made by a Board Certified Anesthesiologist physician determined by the Secretary to be reasonable.

The amendments are contained in six sections, as follows:

The first section amends Section 1814 (b) of the Social Security Act. That section today provides limitations on reimbursement to providers of services. The amendment provides that hospitals may be reimbursed for the services of nurse anesthetists who are their employees on the basis of a fee schedule, rather than the hospitals including their salaries as a part of their overall costs in determining "reasonable costs".

Section 2 provides that the charge for the services of a nurse anesthetist, whether the anesthetist is an employee of a hospital or provides services as an independent contractor with a hospital, shall be deemed to be reasonable if they do not exceed a percentage, determined by the Secretary to be reasonable, of what would be a reasonable charge for the same services if rendered by a physician who is a board Certified Anesthesiologist.

The first section of the Bill deals with the situation where the nurse anesthetist is an employee of the hospital; sections 3 and 4 deal with the situations where the nurse anesthetist is an independent contractor.

Section 3 of the Bill amends section 1861 (s) of the Act to provide that the services of a nurse anesthetist shall not be considered to be "inpatient hospital services" unless the nurse anesthetist is an employee of the hospital.

The amendment made by section 3 then ties in with the amendment made by section 4, which amends section 1861 (s) of the Act to provide that the services of a nurse anesthetist shall be considered to be "medical and other health services" for which reimbursement may be provided under Part B except where the nurse anesthetist is an employee of the hospital where the services are performed.

Section 5 of the Bill amends section 1902 of the Act to provide for the amendment of State plans to provide for direct reimbursement to nurse anesthetists who are hospital employees, and for reimbursement to hospitals for services of nurse anesthetists who are their employees, in amounts for their services up to the reasonable charge for those services prescribed by the amendment made by section 2 of the Bill.

Section 6 amends section 1905 of the Act to include the services of a nurse anesthetist as among those services for which reimbursement may be provided under State plans, and the amendments made by subsections (b) and (c) provide that the State plans must provide for services of nurse anesthetists.

Our recommendations set forth above were drafted in such form that they could be presented as a separate Bill. We hope, however, Mr. Chairman, that the language will be included as a part of S. 1470. Thus, the Bill would deal with Anesthesiologists and their role; and an additional section will deal with Nurse Anesthetists and their role.

President Carter and his Administration have expressed their great concern for the increasing costs of health services. The Congress has also done so and, in part at least, S. 1470 is directed to these problems. We believe our recommended amendments pertaining to Nurse Anesthetists are very much in keeping

with the purpose of President Carter and of the Congress and would result in substantial savings to the public.

In our opinion recommendations for amendments to the Social Security Act as they relate to reimbursement for anesthesia services should accomplish three objectives. Specifically—

- (1) Decrease total expenditures spent on anesthesia services by the Government (or other third party payers);
- (2) Provide incentives to the providers of anesthesia to be as efficient as possible (that is the lowest cost without adversely affecting quality); and
- (3) Improve the equity of the various parties involved.

We believe that the proposal which we have presented accomplishes these objectives. However, we recognize that reimbursement of Nurse Anesthetists on the basis of charges poses certain questions. For example, a suggestion has been made that Nurse Anesthetists might move away from salaried employment to self-employment if these amendments were adopted. This is unlikely to occur because of the many advantages identified with an employed status i.e., job security, fringe benefits, malpractice insurance coverage provided by the hospital, etc. Secondly, the overall economic status to the hospital employed Nurse Anesthetists will probably improve and thereby provide little incentive to move away from an employed status. Because of these factors we believe our recommended amendments may well encourage more Nurse Anesthetists to go from a self-employed to a hospital based arrangement.

While it is recognized that salaries of Nurse Anesthetists may increase, the net effect should be a significant reduction in the total cost for anesthesia services. An actual example may make this more meaningful. A 200 bed hospital in a large metropolitan area has one Anesthesiologist and three Nurse Anesthetists on its staff. Last year the Anesthesiologist received \$160,000 for his services and each of the Nurse Anesthetists received, on the average, a salary of \$20,000 (total \$60,000). Therefore, the total cost for professional services was \$220,000. Assuming that the salaries of the Nurse Anesthetists increased to \$25,000 (total \$75,000) as a result of our proposal to allow hospitals to bill charges for their services and assuming that the Secretary of H.E.W. authorized the hospital to bill 20% above cost, the charge for Nurse Anesthetists' services would be \$90,000 (\$75,000 + \$15,000). Secondly, assume that the Anesthesiologist was paid \$20,000 by the hospital for supervisory services. The total hospital cost for anesthesia services would be \$110,000 (\$90,000 + \$20,000). In addition, assume the Anesthesiologist provided services directly to patients and billed \$60,000 for these services. The total cost for anesthesia services would be \$170,000 (\$90,000 + \$20,000 + \$60,000) for a net savings of \$50,000 (\$220,000 - \$170,000) in this one hospital.

	Present	Proposed
Nurse anesthetists:		
3 at \$20,000.....	\$60,000	-----
3 at \$25,000 plus 20 percent.....		\$90,000
Anesthesiologist:		
Billed fees.....	160,000	60,000
Supervision.....		20,000
Total cost.....	220,000	170,000

In this factual example, there is no denying that the salary of the Anesthesiologist will be affected. We would not want to speculate on whether \$80,000 is adequate compensation for this medical specialty. We do believe that the proposal satisfies our three objectives i.e., decreasing total expenditures, maintaining quality, and improving equity.

SELF EMPLOYED NURSE ANESTHETISTS

Our previous testimony and statements discussed the role of the self-employed Nurse Anesthetists who are called upon by hospitals, or members of the surgical staff of hospitals. This occurs where no Anesthesiologist is available and where Nurse Anesthetists are not employed by the hospital, or when additional Anesthesiologists or Nurse Anesthetists are needed. The present Medicare and Medicaid Laws provide the rankest sort of discrimination against these health

professionals. Under the Law a physician can bill the Government directly for his services as an individual practitioner whereas a Nurse Anesthetist who is fully qualified and renders the services is prohibited from doing so.

A letter from the Chairman of this Committee to Ms. Iris Berry, CRNA, dated January 13, 1977 contained the following assurances to correct this situation.

"You will be pleased to know that, as one result of the Finance Committee's hearing on S. 3205, I have decided to make appropriate changes in the revised bill so as to allow for an equitable reimbursement mechanism for those nurse anesthetists who practice their profession independent of hospital employment. I believe that this will help resolve a substantial portion of the problems you raised."

Our reading of the Bill does not indicate that any improvement has been made.

QUALITY OF ANESTHESIA SERVICES

Though our recommendations here relate to the economic aspects of the services provided by Nurse Anesthetists, we have a major and continuing concern for the quality of these services. Substantial efforts are being directed to the education of Nurse Anesthetists. Working with the U.S. Department of Education, our Council on Accreditation is striving to continually improve the education provided. We have also developed a set of standards for nurse anesthesia practice. We are continuing extensive programs of information and education related to new procedures, new techniques and the like, and we have in public testimony, urged the development of a national study of the quality of all anesthesia services, which we believe is badly needed. Our Council on Practice has had correspondence and discussions with the Department of H.E.W. and following preliminary efforts by a committee of knowledgeable persons, they met with representatives of five sections of H.E.W. who have a concern for anesthesia services to discuss the possible assistance of the Department in financing such a study. Unfortunately, they have made little progress with H.E.W. It has seemed to us inasmuch as the public is expending more than \$2 billion a year on Anesthesia Services and the service is provided in such life and death situations that the Government would have a major interest in seeing that a thorough study of the quality of anesthesia services is made. We urge that this Committee and the Congress in its report on this Bill direct the appropriate persons in H.E.W. to see that such a nationwide study is undertaken without further delay.

We appreciate this opportunity to once again bring our views to you and we would be pleased to be of any possible assistance to the Committee. We ask that our complete statement be made a part of the record of these hearings.

APPENDIX A

REVISED SECTION 12 OF S. 1470 INCORPORATING THE CHANGES IN LANGUAGE RECOMMENDED BY AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

HOSPITAL-ASSOCIATED PHYSICIANS

Sec. 12. (a) (1) Section 1861 (q) of the Social Security Act is amended by adding "(1)" immediately after "(q)" and by adding, immediately before the period at the end thereof, the following:

"; except that the term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any professional patient care service unless the service (A) is personally performed by or personally directed by a physician for the benefit of the patient and (B) is of such nature that its performance by a physician is customary and appropriate".

(2) Section 1861 (q) is amended by adding the following paragraphs at the end:

"(2) In the case of anesthesiology services, a procedure would be considered to be 'personally performed' in its entirety by a physician only where the physician performs the following activities:

"(A) Preanesthetic evaluation of the patient.

"(B) Writing an anesthetic management care plan.

"(C) Personal participation in the induction, management, and emergence and assuring that a qualified nurse anesthetist performs any of the procedures which the physician does not personally perform.

"(D) Remaining physically available during the course of anesthesia administration.

"(E) Remaining physically available for the immediate diagnosis and treatment of emergencies.

"(F) Providing indicated postanesthesia care.

Provided, however, That during the performance of the activities described in subparagraphs (C), (D), and (E), the physician is not responsible for the care of more than one other patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E) and a qualified Nurse Anesthetist performs the activities described in subparagraph (C), the physician will be deemed to have personally directed the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E) and the reasonable charge for his personal direction shall not exceed one-half the amount that would have been payable if he had personally performed the procedure in its entirety.

Senator TALMADGE. The next witness is Dr. Richard Ament, president, American Society of Anesthesiologists.

Doctor, if you will insert your full statement in the record and summarize it in 10 minutes in the interests of time, we would appreciate it. I want to thank you and the American Society of Anesthesiologists for your cooperation in drafting this bill.

I am a bit confused. The nurse anesthetists, from whom we have just heard, want to be paid on a fee for service seemingly based on the claim that they do the same thing that you do. I would like to ask you, an anesthesiologist, for your views on this.

Are these practitioners equivalent colleagues?

STATEMENT OF DR. RICHARD AMENT, PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Dr. AMENT. I would like to reserve the opportunity to submit a statement relative to the statement Ms. Ecklund presented for this committee.

Senator TALMADGE. If you will, we would appreciate it.

Dr. AMENT. I will comment, however, on the specific question. I would note that Ms. Ecklund made no reference to the fact that most state laws, including Georgia, by the way, make the acts of nurse anesthetists the responsibility of physicians, who exercise medical judgment in directing the acts of nurse anesthetists; and that also there are new types of physician extenders that will be provided comparable functions in increasing numbers—restricting the law in the manner that the AANA has suggested would restrict the activities of these new individuals.

I would also suggest that we have provided to Mr. Constantine materials that indicate the difference between anesthesiology and nurse anesthetists and I would appreciate it if that material were incorporated into the record.

Senator TALMADGE. Without objection, it will be inserted into the record at this point.

[The material referred to follows. Oral testimony continues on p. 385.]

COX, LANGFORD & BROWN,
Washington, D.C., June 16, 1977.

HON. HERMAN E. TALMADGE,
U.S. Senate,
Washington, D.C.

DEAR SENATOR TALMADGE: At the hearings on S. 1470 held on June 10, 1977, you invited the American Society of Anesthesiologists (ASA) to comment, for the record, on the testimony presented at those hearings by the American Association of Nurse Anesthetists (AANA). ASA welcomes the opportunity to do so, and has asked me to submit these comments on its behalf. The text of this letter has also been approved by Dr. Richard Ament, President of ASA. Accordingly, we would appreciate the insertion of this letter and its enclosures into the record of the hearings.

The thrust of the AANA testimony to your Subcommittee is not new to ASA. AANA, in pursuit of economic objectives on behalf of its membership, has for approximately the past two years engaged in an aggressive campaign in every available forum (including the United States Congress) to call attention to the health care services being provided by nurse anesthetists. ASA does not dispute, nor should it dispute, AANA's right to engage in this campaign on behalf of its membership.

Both in the hearings on S. 1470 and in other forums, however, AANA has unfortunately chosen, as a principal theme of its campaign, a continuing effort (1) to aggrandize the actual and medically appropriate role of nurse anesthetists in the delivery of anesthesia care, and correlatively, (2) to convey the impression that no essential difference exists between the services provided by nurse anesthetists and those provided by anesthesiologists. To this latter thrust, ASA takes the most serious exception, and strongly suggests that by its attempts to bolster this distortion through infinite repetition, AANA badly deserves a medically sound administration of the Medicare and Medicaid programs.

At the request of the Senate Finance Committee staff, ASA prepared some weeks ago a detailed statement of the radical differences in training, clinical experience, and qualifications of nurse anesthetists, on the one hand, and anesthesiologists, on the other. A copy of this statement is attached to this letter as an enclosure.

As explained in the enclosed statement, anesthesiologists are *physicians*, who prior to beginning their practice have specialized as residents in anesthesiology for two to four years, *after* basic training in the sciences as pre-medical undergraduates and after being trained as general physicians in four years of medical school and an additional period of one to two years in internship. By contrast, nurse anesthetists are nurses who have received 18 to 24 months of basic technique-oriented training in the administration of anesthetic agents.¹

From the point of view of Medicare and Medicaid reimbursement, and from the perspective of quality of patient care in those programs, the important question is not, however, the respective lengths of training which anesthesiologists and nurse anesthetists have received, but rather what that training prepares its recipients to do. In brief, anesthesiologists are trained and qualified to provide total anesthesia care as physicians, including the evaluation, diagnosis, and treatment of the patient from an anesthesia perspective. Nurse anesthetists, on the other hand, are trained only to administer anesthetic agents and to monitor certain routine body functions. They are neither trained in, nor possess, the disciplines of pharmacology nor physiology necessary to the provision of total anesthesia care.

The services which anesthesiologists render, over and above administration of the anesthetic agent and the monitoring of body functions (which actually constitute a relatively small portion of total anesthesia care) are critical in all three states of the anesthesia plan: preoperative, intraoperative, and postoperative. Thus, when the patient first enters a hospital, an anesthesiologist physically examines and medically diagnoses the patient from an anesthesia perspective—a

¹ ASA has been active in its efforts to improve the quality of this training, which in many schools of nurse anesthesia has not involved significant physician input, and has not been subjected to necessary critical evaluation. Attached to this letter is a recent presentation by ASA to the Council on Post-Secondary Accreditation, dealing with this subject.

perspective quite different from that of the surgeon. Based upon that examination, he prescribes an anesthesia plan to meet the needs of both the surgeon and the patient. He may also prescribe preoperative medications at this point. (See pages 4 and 5 of the enclosed memorandum.)

In the operating room or obstetrical suite, an anesthesiologist continues to evaluate and treat the patient on an individual basis. For example, in a prolonged operation, an anesthesiologist may keep the patient in a relatively light stage of anesthesia for the major portion of the anesthesia, but may utilize a deeper stage of anesthesia during certain critical moments. Determining the length and depth of anesthesia that a particular patient can withstand at a particular moment requires medical skill and judgment of the most exacting caliber. (Other examples of the intraoperative services routinely rendered by an anesthesiologist are contained in page 5 of the enclosed memorandum.)

Finally, during the postoperative period, an anesthesiologist supervises the equally critical process of emergence, monitors the patient for after-effects of anesthesia and surgery, and immediately administers acute care whenever required. This process requires an understanding of the degree of respiratory and circulatory depression the patient has undergone, as well as the medical knowledge and judgment to deal with emergencies and abnormalities.

All of the elements of anesthesia care listed above must be performed by a physician. If an anesthesiologist is not available, then they must be performed by the surgeon. A nurse anesthetist is not qualified, legally or as a medical matter, to perform any of these functions. (In fact, due to the increasing complexity of anesthesia techniques and the growing number of anesthesia drugs—all potentially lethal—even the surgeon frequently does not have the knowledge or the time to prepare or implement an optimal anesthesia plan.)

ASA does not dispute the fact that a properly trained nurse anesthetist can play a valuable role in the execution of the anesthesia plan, but if, and only if, that role is carried out under the direction of a licensed physician—preferably an anesthesiologist. AANA in its statement makes reference to the fact that certain apparently large percentages of the anesthetics administered in this country are administered by nurse anesthetists. What AANA fails to state is that those anesthetics are administered by a nurse anesthetist under the direction of a licensed physician (the surgeon or, less frequently, an anesthesiologist) in the smaller hospitals, and under the direction of an anesthesiologist (who may also physically participate in such administration) in the vast majority of larger hospitals and in virtually all of the tertiary care centers in this country.

S. 1470 fully and properly contemplates the desirability, under Medicare and Medicaid, of anesthesiologist direction of the administration of anesthetics by nurse anesthetists. As you know, we have supported the Subcommittee's efforts in this respect. As you also know, ASA believes that from a medical point of view, there is no substitute for a one-to-one relationship between anesthesiologist and patient; given, however, the manpower shortages of anesthesiologist in some parts of the country, and the need for participation of both anesthesiologists and nurse anesthetists in centers for more complex and protracted surgical procedures, we have also readily agreed that appropriate administration of the Medicare and Medicaid plans must include the concept of medical direction by an anesthesiologist of the work of nurse anesthetists.

On page 8 of their statement, AANA cites as an appropriate objective for amendment to the Social Security Act the provision of "... incentives to the providers of anesthesia to be as efficient as possible (that is, the lowest cost *without adversely affecting quality*)." (Emphasis added). ASA is in total accord with this objective, and believes that the provisions of S. 1470, dealing with anesthesia care, are precisely directed toward this end, in that they:

(1) eliminate reimbursement methods for hospital-associated physicians on the so-called "percentage" basis, under which there may, or may not, be a direct relationship between physician services and actual reimbursement;

(2) provide incentives to anesthesiologists to engage in the medical direction of nurse anesthetists and other non-physician anesthesia personnel (*e.g.*, anesthesiologists assistants), thereby making available to patients on a broader basis the medical skill possessed by the anesthesiologist; and

(3) provide disincentives to an anesthesiologist attempting to direct or supervise the anesthesia services of more non-physician personnel than can be justified in terms of proper patient care.

I hope that the foregoing comments are helpful to your Subcommittee in its consideration of the AANA statement. If ASA can provide further information, please advise me.

Very truly yours,

MICHAEL SCOTT,
Cox, Langford & Brown,
Counsel to ASA.

Enclosures.

ORAL PRESENTATION TO COPA, ON THE ACCREDITATION OF AANA-CA

I am Richard Ament, M.D., Clinical Professor of Anesthesiology at the State University of New York at Buffalo and also, during the current year, President of the American Society of Anesthesiologists. I appreciate the opportunity to appear before this distinguished committee to speak on behalf of our Society in opposition to the application of AANA's Council on Accreditation for recognition as an accrediting agency.

We have already made clear in our written submission the principal reasons for our opposition. I will only summarize them here. Essentially, our concern is that the track record both of the AANA and its captive, the Council on Accreditation, is characterized by a regular, and continuing denigration of the need for physician input in the operation and accreditation of schools of nurse anesthesia. This record includes the following:

1. Reluctance to include physician educators on the Council, and ultimate inclusion of only that number of physicians as appear politically expedient in order to obtain recognition under the minimal standards of the HEW Office of Education.

2. Failure to include significant numbers of physicians on site visitation teams, and failure to include in these teams *any* academically oriented anesthesiologist.

3. Refusal of the Council to recognize or accord any voice to the Association of Faculties of Nurse Anesthesia Schools, an organization having equal institutional representation of physician and nurse anesthesia faculty members of the very schools that the AANA-CA accredits.

4. Requirement in the Council's accreditation standards that at least one CRNA, so certified by AANA, on an annual basis, be included on the faculty of a school of nurse anesthesia, but *no* requirements that a physician be so included.

5. Failure or refusal by AANA to provide to our Society or to the American College of Anesthesiologists, AANA membership lists so as to make it impossible for these organizations to effectively advise the AANA membership of programs of continuing education offered by physician organizations.

6. Declining willingness to permit anesthesiologists to present technical papers in the AANA Journal or at the AANA Annual Meeting, even though almost all pharmacological and anesthesiology research is being carried out by physicians and none by CRNAs.

7. Formal statements by AANA representatives to the Congress that, in spite of enormous differences in the length and quality of training, nurse anesthetists provide service equivalent to anesthesiologists.

All of these postures add up to an effort by AANA—and the accreditation process is only one facet of the entire picture—to establish independent purveyor status for its membership. Without question, a mandatory aspect of this effort is to shed any public appearance of reliance by AANA, its Council on Accreditation, or its membership, upon physician knowledge, skill and leadership, even though the AANA continues to pay formal lip service to the leadership of an anesthesiologist on the care team.

While this may well suit AANA's political and economic purposes, one may seriously question whether this side effect of physician denigration is in the interest of the health care system. We are not talking here about the training of accountants—who do not deal with patient's lives—we are talking about the training of individuals who will be administering lethal drugs on a daily basis. The chemistry of anesthesia is both complex and dangerous, and no matter what the legitimate economic aims of the AANA is, there is no excuse for the lack of adequate physician input into the training of nurse anesthetists and the accrediting of the schools which provide that initial training.

It is entirely consistent with this ANA approach, however, that in advising its membership of the recent continuing recognition by the Office of Education of the AANA Council as the accrediting body, AANA failed to make any mention of the conditions imposed by the Office of Education on that recognition. Those conditions are referred to in our written presentation and focus principally on the question of physician input to the accrediting process and to the lack of independence of the Council on Accreditation. Equally consistent is AANA's failure to refer in these same materials to the testimony of AANA's own witness at the Office of Education hearing—Dr. C. Ronald Stephens—that this physician involvement is inadequate, and that necessary autonomy is lacking.

On the question of autonomy of the Council, I wish to make clear our view that in no real sense can AANA claim that the Council is truly independent. A "moratorium" on AANA's control over the Council Bylaws merely bespeaks a continuing intention to supervise. When one also considers that the Council relies upon AANA for almost fifty percent of its operating funds and that AANA itself is entitled to nominate a substantial majority of the Council members, the conclusion is inescapable that autonomy is lacking. In the view of ASA, autonomy of the Council is critical to broad acceptance of its decisions on the accreditation process.

As physicians ultimately responsible for anesthesia care, and as the acknowledged leaders of the anesthesia care team, we are deeply concerned by the limited quality of nurse anesthesia education today—a situation which we believe to be the direct product of insufficient physician participation, and the interdependence of the Council on Accreditation with AANA, an organization principally political in character. Until 1975, the Council had approved *all* applications for accreditation. Today, of the 181 schools of nurse anesthesia, less than 30% are academically affiliated. Comparatively, of the 158 approved residencies in Anesthesiology, only nine are not academically affiliated. I find, moreover, that the accreditation standards and self-evaluation procedures of the Council are characterized by a rigid, technically oriented approach to curriculum, to the detriment of the more flexible academic approach. To me and other anesthesiologists, this characteristic raises the fundamental question concerning the quality of nurse anesthesia education—and it is this quality which, in the long run, is our fundamental concern.

The Council, in its application to COPA, alleges that its standards have received broad acceptability. To the contrary, ladies and gentlemen, the present accreditation and credentialing process is neither acceptable to a large number of nurse anesthetists and anesthesiologists, nor to the ASA, nor to the Office of Education. Currently, the only way in which acceptability is going to be possible, is if AANA is forced to include greater physician input in its Council on Accreditation and grant this Council true autonomy. Recognition of the Council in its present posture certainly will not serve that end.

5/15/77

DIFFERENCES IN SERVICES PROVIDED BY
ANESTHESIOLOGISTS AND NURSE
ANESTHETISTS

It is both superficial and inaccurate to equate the services performed by anesthesiologists, who are physicians engaged in the practice of medicine, with special training in the medical aspects of anesthetics, with non-physician nurse anesthetists, who are registered nurses with special training in the performance of anesthesia techniques. While some (but by no means all) technical procedures are performed both by anesthesiologists and nurse anesthetists, the critical distinction between the two disciplines arises from fundamental disparities in knowledge, skill, training, application of medical judgment, legal qualification, and professional and legal responsibility. Patients deserve and must have available on a continuing basis the medical judgments that are necessary for their proper anesthesia and surgical care. The nurses' background precludes this very necessary ingredient, while the physicians' education and training are directed toward being able to provide such rational medical decisions under changing circumstances.

I. EDUCATION

- A. The usual prerequisite to specialist training in anesthesiology is a Bachelor of Arts or Science degree following high school, usually from a major university of high academic standing (4 yrs.), a comprehensive entrance examination (MCAT), and competitive admission procedures to a medical school which requires a high grade point average (GPA) in undergraduate school. An M.D. degree follows indepth basic science education (biochemistry, biophysics, anatomy, physiology, pharmacology, pathology) plus extensive clinical exposure to diagnosis and therapy (4 yrs.)

FMGs* must have passed the ECFMG examination. Most resident programs require a minimal grade for the ECFMG of 80. (The FMG program is being phased out by the Health Education Assistance Law of 1976).

*FMG - Foreign Medical Graduate

- A. The prerequisite for admission to nurse training schools is (1) a two-year course in nursing arts (RN) in a community college which may have modest admission standards, modest academic levels in basic science courses and inadequate clinical exposure; or (2) a three-year diploma course in nursing arts (RN). Three year schools in general provide a good clinical experience but a varied didactic exposure; or (3) a four-year baccalaureate program in nursing (RN) in a college or university with a wide variation in academic level and minimal clinical exposure.

The 1975 candidates for CRNA certification were distributed as follows: 2-year RNs - 25%; 3-year RNs - 54%; 4-year RNs - 16%; foreign graduates and masters degrees - 4%. Since three-year schools are being phased out gradually, 1977 candidates are probably closer to 40% two-year RNs, with commensurate lower level of admission qualification.

Continued...

The CRNA program is identical regardless of whether the RN prerequisite is obtained in two years, three years or four years. This fact was recently cited as a principal basis for the recommended denial to the American Association of Nurse Anesthetists, which purports to accredit schools of nurse anesthesia, through a semiautonomous council (AANA-CA), of recognition by the Council on Post-Secondary Accreditation (COPA), a private education association engaged in evaluation of accrediting standards.

- B. A three-year progression of advanced education in anesthesiology, designed to lead to assumption of full medical and legal responsibility as a specialist physician, including two years of varied clinical exposure, one year in related services of cardiology, intensive care, pain therapy, pulmonary function, respiration therapy, renalogy, and research. A fourth year of optional subspecialization: cardiovascular, neurosurgical, pediatric and obstetrical anesthesia.

Of 158 resident programs, only nine are not university affiliated. University affiliation provides residents not only with the opportunity for interaction with other medical specialist disciplines, but also with the basic ingredients of university life - academic inquiry, research, and professional self assessment. The Residency Review Committee, which is independent of the American Society of Anesthesiologists, has dropped approximately 80 programs in the past five years, as a part of its continuing evaluation of all residency programs.

C. Total Education Sequence:

11-12 years

- B. An 18 month (and a few 24 month) program of technique-oriented training, requiring completion of specific numbers of procedures classified by anesthetic agents, techniques, types of operation. Academic requirements may be limited and elementary. Those that are associated with academic institutions are generally of higher caliber.

Of 186 nurse anesthetist schools, fewer than 30% are academically affiliated. Only six offer an academic degree (B.A. or B.S.). AANA-CA has dropped approximately ten programs in the past ten years.

The Office of Education provided only one year approval for AANA's accreditation process in 1975 and, despite a three-year approval in 1976, requested remedial action within one year relative to lack of autonomy, lack of anesthesiologists' involvement in accreditation policy decisions and site visits, and the tie-in of certification of nurse faculty to AANA membership. As noted above, a review panel of COPA - a private evaluator of accreditation programs - in early 1977 recommended that the AANA-CA be denied recognition by the COPA Board.

C. Total Education Sequence:

3.5-5 years

Continued...

- D. In-Training Examination for residents is requested annually. Residents must have passed a licensing examination after the first post-doctoral clinical year of training.
- E. Certification by the American Board of Anesthesiology through written in-training examination and oral examination after one or two years of practice. While 85% of candidates who stay in the examination system eventually pass, a 40% failure rate occurs on the first try of this examination. This is an autonomous system, unrelated to the American Society of Anesthesiologists; ASA membership is unrelated to certification. Recertification is planned to begin in 1984.
- F. Continuing Education Requirements are generally on voluntary basis, although they are now mandated in 17 states by the state governing bodies and in 16 additional states by the state medical associations.
- ASA provides six regional refresher courses and four regional workshops annually, plus five rooms of refresher courses for two days during its Annual Meeting. An average of 1800 anesthesiologists attended regional courses in the past three years; more than 3500 anesthesiologists annually attended the ASA meeting during the same period. Over 100 continuing education programs are presented by state and local medical groups, medical schools and hospitals.
- G. Voluntary Self-Assessment Examinations are available for active practitioners.
- H. Research: Most physiological and pharmacological research in the field is carried out by anesthesiologists.
- I. Teaching: Anesthesiologists are responsible for teaching most medical students not only anesthesiology and
- D. None
- E. Certification by the AANA Council on Certification, on the basis of a written examination only. There were few failures prior to 1975. AANA membership must be maintained annually or certification is withdrawn. The Council is not autonomous.
- F. Continuing Education Requirements are on a voluntary basis. Few courses were provided by the AANA or state or local associations prior to 1976. Nurse anesthetists seek to attend, to some degree, continuing education programs for anesthesiologists. ASA has provided full morning programs for nurse anesthetists at two past annual ASA meetings and two regional refresher courses are planned for nurse anesthetists during 1977.
- G. None
- H. Almost none.
- I. Teaching: Provide basic and clinical training in nurse anesthesia schools usually with the cooperation of anes-

Continued...

pharmacology, but also resuscitation techniques, respiratory therapy and intensive care. Formal academic organizations have been established (Society of Academic Anesthesia Chairmen and Association of University Anesthetists) to assist faculties in all aspects of their activities through a variety of committees and national and regional meetings.

- J. Literature: Extensive textbooks are authored by anesthesiologists. Four American and several foreign journals provide a scientific base of knowledge in anesthesiology. All are edited by anesthesiologists

The Wood Library Museum in Chicago and the Guedel Center in San Francisco provide a repository of anesthetic equipment and world literature. These are an invaluable resource for materials related to the history and science of anesthesiology.

thesiologist faculties. While an Assembly of Schools is convened annually to discuss teaching methods, no formal faculty organization has been accepted by the AANA even though one has been organized with both a nurse anesthetist and anesthesiologist representing each nurse anesthesia training school: The Faculties of Nurse Anesthesia Schools (FNAS).

- J. Literature: The AANA Journal is primarily made up of review articles written by CRNAs with bibliographies constructed from material published almost exclusively by anesthesiologists (see attached article). Since AANA has started its campaign with the government for independent purveyor status, almost no anesthesiologists are invited to present scientific papers at the AANA's Annual Meeting and, consequently, almost no scientific papers by anesthesiologists appear in the AANA Journal.

II. CLINICAL PRACTICE

- A. Preoperative Preparation of the Patient: The preoperative preparation of the patient for anesthesia by an anesthesiologist provides services including but not limited to the following:

1. History and physical examination particularly relating to anesthetic history and the cardio-respiratory systems.
2. The ordering and interpretation of appropriate tests other than the routine, such as blood gases, electrolytes, digoxin level, enzymes and pulmonary function parameters.
3. The diagnosing and treatment of such aberrations as pulmonary insufficiency and fluid and electrolyte imbalance.
4. The overall evaluation of the patient as an anesthetic risk.

- A. Preoperative Preparation of the Patient: While some portions of preoperative care do involve nurse anesthetists acting under a physician's direction and responsibility, the items in column one constitute the practice of medicine and the nurse anesthetist is not capable of performing these acts either by training or by law.

Continued...

5. The ordering of preoperative medications and evening sedation and in other cases making the decision not to prescribe these medications.
6. The obtaining of an informal consent and establishing a personal rapport with the patient.

B. Intraoperative Care of the Patient:

The intraoperative care of the patient provides services by an anesthesiologist including but not limited to the following:

1. The prescription of an anesthetic plan and the carrying out of this plan of anesthetic administration based on his preoperative evaluation and preparation of the patient.
2. The management of fluid and blood replacement and the diagnosing and treatment of electrolyte and coagulation abnormalities.
3. The diagnosis and treatment of cardiac arrhythmias, ischemic and failure.
4. The obtaining and interpretation of blood gases and diagnosing and treatment of respiratory and gas exchange abnormalities.
5. The insertion of arterial, Swann-Ganz catheters, and other monitoring devices.
6. The diagnosing and treating of intraoperative complication such as hyperthermia, hypertension, insulin shock, and adrenal insufficiency.
7. Administration of regional anesthesia by spinal, epidural and nerve block techniques.

C. Postoperative Care of the Patient:

In the postoperative care of the patient, the anesthesiologist provides services including, but not limited to, the following:

1. Management of postoperative pain including the prescription of drugs and conduction anesthesia.
2. Management of fluid balance and the diagnosing and treatment of volume, osmolar, and electrolyte abnormalities.

B. Intraoperative Care of the Patient:

The items in column one constitute the practice of medicine. A nurse anesthetist administers an anesthetic and monitors the patient under the direction of a physician. Nurse anesthetists are not capable by training or by law of diagnosing and treating disease or of performing regional anesthetic techniques.

C. Postoperative Care of the Patient:

The items in column one constitute the practice of medicine and the nurse anesthetist is not capable by training or by law of providing these services.

Continued...

3. Management of nausea and vomiting by the prescription of drugs and the diagnosing and treating of specific etiologies.
 4. Diagnosing and treatment of cardiac arrhythmias, failure and ischemia.
 5. Diagnosing and treatment of respiratory insufficiency.
- D. Subspecialties:
Anesthesiologists, in order to develop and apply advanced anesthetic techniques and special medical judgments to narrower fields of medical endeavor, have developed areas of subspecialty expertise and subspecialty societies. These include:
1. Section on Anesthesia, American Academy of Pediatrics
 2. Association of Cardiac Anesthesiologists
 3. Society of Critical Care Medicine
 4. Society of Neurosurgical Anesthesia and Neurologic Supportive Care
 5. American Society of Regional Anesthesia
 6. Society for Obstetric Anesthesia and Perinatology
- Some of these subspecialists have been trained and board certified in two medical disciplines such as Anesthesiology and Pediatrics or Anesthesiology and Obstetrics. These activities are encouraged and supported by the ASA.
- E. Non-operating Room Activities
The Recovery Room: The anesthesiologist is generally in charge of the recovery room. He sets up guidelines for the recovery room and training programs for recovery room nurses. Discharge criteria and treatment in the recovery room falls under the anesthesiologists' responsibility and direction.
- D. Subspecialties:
While some nurse anesthetists function in a subspecialty area, no activities by AANA support such specialization.
- E. Non-operating Room Activities
The Recovery Room: When no anesthesiologists are on the hospital staff, nurse anesthetists carry out instructions of the responsible surgeons in post-anesthetic emergencies.

Continued...

Intensive Care Units: Anesthesiologists have assumed administrative and clinical responsibility for intensive care patients in many hospitals, managing ventilatory care, fluid and electrolyte control. In some ICU's, this is a shared responsibility with chest physicians and surgeons. In some instances, anesthesiologists provide strictly consultative support to these units.

Cardiopulmonary Resuscitation: Much of the original experimental work on CPR was accomplished by anesthesiologists. Anesthesiologists continue to be involved in the forefront of teaching CPR, and participating in medical team efforts in CPR within each hospital.

Respiratory Therapy: Approximately 40% of respiratory therapy departments are directed by anesthesiologists. Anesthesiologists also provide medical consultation for patients with pulmonary problems and prescribe respiratory therapy.

Pain Therapy: Because of the anesthesiologists' study of painful states and his familiarity with techniques of nerve block and other modalities of pain control, the anesthesiologist is usually the primary consultant to be called to diagnose and treat painful syndromes.

Intensive Care Units: Nurse anesthetists may provide airway support by endotracheal intubation upon request in those hospitals without adequate anesthesiologist support. They are usually not involved in the care of patients in the ICU except as part of a resuscitation team.

Cardiopulmonary Resuscitation: The nurse anesthetist may be called upon to manage the airway in resuscitation efforts. Occasionally nurse anesthetists become involved in teaching basic life support techniques.

Respiratory Therapy: Occasionally a nurse anesthetist may function as a chief respiratory therapist who administers respiratory treatment and directs respiratory therapy technicians. These duties are under the direction and prescription of a physician.

Pain Therapy: There is little or no involvement of nurse anesthetists in this area of treatment.

III. ANESTHESIA CARE TEAM

The 1972 Joint Statement, as well as the 1976 AANA proposal for revision and the 1977 ASA proposal for revision, are attached. While professing to support the concept of the physician as the director of the care team, even in their 1976 statement, the AANA has stated in presentations before congressional committees, the Social Security Administration and other government agencies that their services are on parity to that provided by anesthesiologists and they should, therefore, be eligible for independent purveyor status under Medicare.

IV. PATIENT RESPONSIBILITY

Under most state laws, the practice of medicine is defined to include diagnosis, prescription and therapeutics; expressly or by implication, these laws also require that nurse anesthetists function under the direction of a physician -- a surgeon, if an anesthesiologist is not present.

The Joint Commission on Accreditation of Hospitals requires that departmental heads define and review the qualification and duties of non-physician personnel in their respective departments. Anesthesiologists in private practice who are the chairmen of anesthesiology departments, in a hospital employing nurse anesthetists, have been charged with vicarious liability for the acts of hospital-

Continued...

employed nurse anesthetists.

Anesthesiologists today pay annual premiums of \$3,000 to \$40,000 for professional liability insurance; nurse anesthetists \$300 to \$900. These disparities directly relate to the medical and legal responsibility assumed by the two types of practitioner, respectively.

SUMMARY AND CONCLUSION

Given the differences referred to above, it seems clear that proper anesthesia care requires, for the foreseeable future, a systemic approach to the rendition of patient care. The nurse anesthetist is equipped neither by education, training nor experience to function properly on a basis independent of anesthesiologist, or at least physician, direction. In the last analysis, the critical difference lies in the application of medical judgment to the patient's condition and needs. The technically-trained and experienced nurse anesthetist does not, by definition, possess that judgment. The physicians' entire educational exposure (the basic sciences in undergraduate school; physiology, pharmacology and other basic disciplines in medical school and in this clinical application of this knowledge and the knowledge gained through formal and informal programs of continuing medical education) conditions his every activity in the practice of his specialty in a technique of critical patient observation.

Dr. AMENT. I would like to proceed with my comments on my statement at this time.

Senator TALMADGE. You may proceed.

Dr. AMENT. My name is Richard Ament, and I am a physician engaged in the practice of anesthesiology in Buffalo, N.Y., and I am currently president of the American Society of Anesthesiologists.

ASA is an organization of some 14,000 physicians, 11,000 of whom are actively engaged in the practice of anesthesiology. The position of the ASA on S. 1470 is set forth in our written presentation, copies of which are before the members of the subcommittee. I do not intend to read that statement. In essence, ASA is supportive of those portions of S. 1470 dealing most specifically with the practice of anesthesiology and seeks only minor clarification of the bill, along the lines already discussed with the Finance Committee staff.

We do advocate, however, the reinsertion into S. 1470 of the proposed 80-percent floor on medicaid reimbursement for all physicians. As discussed in our statement, the reimbursement to anesthesiologists under medicaid today falls far below this level to the point where anesthesiologists are becoming less and less inclined to accept medicaid patients.

While we are intellectually sympathetic with those who advocate that medicaid reimbursement should be no different than that under medicare, we believe, as practical individuals, that some improvement in the situation is better than no improvement at all, not only from the point of view of the anesthesiologists but also from the point of view of medicaid patients who require our care.

I would like to take the remaining amount of time allotted to me by the subcommittee to offer some general thoughts which are my own and not necessarily those of ASA. It is well-known to the committee and the staff that ASA has departed markedly in its approach to S. 1470 and its predecessor, S. 3205 from several other elements of organized medicine, including most particularly the American Medical Association.

AMA, in its formal statement to the committee yesterday, expressed its strong opposition to those portions of the bill that attempted to define the context and the basis upon which the Federal Government will reimburse anesthesiologists and other specialists for professional services rendered to medicare patients.

AMA's underlying philosophic ground is that this proposed Federal action amounts to a definition of the practice of medicine, an enterprise in which the Government should not be engaged. ASA, on the other hand, thought that the chairman's initial proposals last year involving condemnation of percentage arrangements, requiring that reimbursement of anesthesiologists and others be tied to personal performance or personal direction of medical services, and generally supporting the right of organized medicine, collectively to deal with the Federal Government, in organizing levels of reimbursement were almost indirect accord with ASA's published ethical standards for the practice of anesthesiology and other statements of ASA's position.

ASA has thus been publicly supportive of the chairman's effects, and privately cooperative with the committee and its staff in the articulation of these principles in S. 3205 and S. 1470.

Let there be no mistake, however. Neither ASA nor its membership is enthusiastic about congressional standards-setting which threatens, or tends to threaten, the freedom of choice of the individual physician to determine how he will practice medicine. That we appear to be moving in the direction of a national medicare physician fee schedule, I assure you, is a development that is not greeted with unbounded joy by our society or by the individual anesthesiologist.

On the other hand, I believe that the time has passed when organized medicine can choose to ignore legitimate interests of the Federal Government in determining the context in which it will pay for physician services. We may not like the fact that the Federal Government is in this act at all, but the simple fact is that no real likelihood exists that participation by our Government in the provision of medical services is going to diminish.

Given this very practical and somewhat painful situation, I believe that we at ASA have a responsibility to our membership to devote our principal efforts to assure that the reimbursement mechanism is of a minimal complexity and conforms as closely as possible to what we view as the ethical and sound practice of anesthesiology.

We owe this responsibility, not only to our membership but to the consumer of medical services as well, for if, by virtue of legislative or regulatory action the Federal reimbursement mechanism and the ethical and proper practice of medicine are not in close harmony, the principal losers will be the federally insured patients whom the physician will either decline to serve or will serve only with reluctance.

ASA is presently engaged in antitrust litigation brought by the Department of Justice, the purpose of which is to test the legal validity of one method by which organized medicine at the national, State, or local level may participate in the development of the reimbursement mechanism. Or, perhaps more accurately, in the definition of appropriate relative reimbursement standards for various medical procedures.

Not only do we regard this as a constitutional right of organized medicine under the first amendment right of petition, but we believe that the full participation of physicians and organized medicine in this process at every stage is essential to a practical medical care delivery system at a cost which this country can afford.

Thus, both with reference to this bill and with other similar legislation or regulatory proposals which undoubtedly lie ahead, ASA's posture will undoubtedly be to participate directly in the development of appropriate reimbursement mechanisms. Where reimbursement proposals promote ethical and sound anesthesiological care, we will support them. Where they do not, we will work aggressively to change them, just as we have done during the course of development of this bill and in various negotiations with the HEW bureaus.

Thus, during the past several months, ASA has acted to bring about changes in medically inappropriate BHI reimbursement standards for anesthesia payments for cataracts, surgically and medically unsound BQA standards for a standard postanesthesia note, medically unreasonable BHI regulations concerning reimbursement of anesthesiologists for the medical direction of anesthesiologists-in-training and nonphysicians as well.

In all of these situations, ASA has devoted countless hours and waited countless months for rational revisions of medically misdirected Federal regulations. This is a frustrating process, just as it is frustrating for me to hear Secretary Califano earlier this week once again attack percentage arrangements involving anesthesiologists, despite our long history of opposition to these arrangements, despite the fact that 90 percent of anesthesiologists practice in fee-for-service settings and, despite the fact that, as pointed out in recent ASA correspondence to Secretary Califano, which we submit for the record, the practical remunerative effect to anesthesiologists from percentage arrangements on HEW's own figures is modest indeed.

[The following was subsequently supplied for the record:]

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS,
Park Ridge, Ill., May 19, 1977.

Hon. JOSEPH A. CALIFANO,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR SECRETARY CALIFANO: I am writing you this letter in my capacity as the current President of the American Society of Anesthesiologists (ASA), an organization of approximately 11,000 physicians actively engaged in the practice of anesthesiology.

My purpose in writing is to express my keen disappointment in the remarks attributed to you in the May 18 issue of The Washington Post, in which you are quoted as recommending that hospitals "negotiate 'much more firmly' with specialists such as pathologists, radiologists, and anesthesiologists who *often* 'get a percentage of the gross' income of their departments. That is like the entertainment business . . . this is not the entertainment business" (emphasis added).

In brief, I believe that the facts will demonstrate that if accurately quoted, you owe an apology to ASA and its membership for this blanket characterization of the way in which anesthesiologists are compensated for their professional medical services, and for the clear implication from the story that the amount of compensation received by anesthesiologists for their services is excessive.

In the first place, the ASA has for many years formally and publicly opposed the billing for anesthesiology services on a percentage basis. The current Guidelines to the Ethical Practice of Anesthesiology (as amended by the ASA House of Delegates on October 15, 1975) states in pertinent part as follows:

"Final return from the private practice of anesthesia should be on a fee-for-service basis. . . . Anesthesiologists should not permit a hospital to bill or collect for his services as an anesthesiologist. . . . It is unethical for a physician to be paid by a hospital for professional service to individual patients who pay the hospital for such service . . .".

Consistent with this policy, ASA (virtually alone among organized medical societies) last year testified *in favor* of the provisions of the Talmadge Bill (S. 3205) dealing with a prohibition against percentage arrangements. In his statement before the Subcommittee on Health of the Senate Finance Committee, presented in July, 1976, then-President John W. Ditzler of the ASA stated as follows:

"We agree, as an ethical matter, that physician reimbursement arrangements, based upon a percentage of hospital income or receipts, are inappropriate."

As you know, the use of percentage reimbursement arrangements for physicians was then and is now a subject of major concern to Senator Talmadge and the members of his Subcommittee, and I believe that if you will inquire of the Senator or members of the Subcommittee staff, you will find that ASA is regarded as a major supporter of the Senator's views, both in this, and in other areas, relating to appropriate containment of health care costs.

I find your statement all the more offensive in light of a recent study prepared by Arthur Andersen & Co. for the *Social Security Administration*, relating to reimbursement in practice arrangements of "provider-based" physicians (March 1977; Contract No. 600-76-0055). In part, that study compared annual earnings

of physician specialists in three categories—radiologists, pathologists, and anesthesiologists—depending upon whether the specialist was compensated on a salary basis, or a percentage basis.¹ I trust you will find the findings of your own study as illuminating as I did:

1. Average full-time earnings of a *radiologist* on a salary basis was \$52,600 per annum, as compared with average full-time earnings of \$124,400 under a percentage compensation arrangement. The latter figure is 237% of the former.

2. Average full-time earnings of a *pathologist* on a salary basis was \$49,200 per annum, as compared with average full-time earnings of \$138,200 under a percentage compensation arrangement. The latter figure is 281% of the former.

3. Average full-time earnings of an *anesthesiologist* on a salary basis was \$62,300 per annum, as compared with average full-time earnings of \$87,400 under a percentage compensation arrangement. The latter figure is only 140% of the former.

I trust you will note that the difference between the two compensation arrangements, both in absolute dollars and in terms of ratio, is radically smaller for the anesthesiologist than for either the radiologist or pathologist. As acknowledged by the study, moreover, numerous fringe benefits and other costs (*e.g.* professional liability insurance premiums which, in the case of an anesthesiologist, may range up to \$25,000 or \$30,000 a year)—normally absorbed by the *hospital* under a salary arrangement—are assumed by the *physician* on a percentage arrangement. In short, whatever may be true of other specialties, your own study reveals that entirely aside from important *ethical* considerations which lead ASA to oppose percentage arrangements, there is relatively little financial advantage (if any) to the anesthesiologist from such an arrangement.

Finally, as you might anticipate by virtue of my present position with the ASA, I have had the opportunity both this year and over the past several years to come into contact with practicing anesthesiologists from all parts of the United States. I personally am not familiar with one single case of an anesthesiologist who is compensated on a percentage basis. This is not to say that I do not believe such cases exist, but I do take the most serious issue with your characterization of these arrangements for anesthesiologists as “often” occurring. I believe they in fact occur only with rare exception in the United States today.

Quite frankly, both I and ASA have grown weary—particularly in view of the Society’s condemnation of percentage arrangements over the past several years and in view of our open support of the Talmadge proposals—of what we believe to be a continuing and repeated distortion of truth concerning the methods by which anesthesiologists, with very few exceptions, are compensated for their services. If HEW is possessed of information—as implied in *The Washington Post* story—that our understanding of the truth is incorrect, then we will be very glad to know it. For this reason, please regard this letter as a request, under the Freedom of Information Act (5 U.S.C. § 552) for any information (and supporting documents) possessed by your office, HEW, the Social Security Administration, or the Bureau of Health Insurance concerning the number or proportion of anesthesiologists currently being compensated under a percentage arrangement, and the average or assumed compensation earned by such anesthesiologists as a result of such arrangements.

Very truly yours,

RICHARD AMENT, M.D.,
President.

Dr. AMENT. What we ask of this committee, of the Secretary and HEW as a whole is, while they wrestle with the problem of maintaining the national cost of medical care at a manageable level, they also respect the fact that physicians, and not departmental administrators, best understand the practice of medicine as it exists and as it should exist, between physician and patient.

To do otherwise, I suggest would destroy the foundation on which the entire system rests.

¹ The survey covered 120 hospitals, that did not purport to report earnings of physicians compensated on a fee-for-service basis—the compensation basis far most commonly utilized by anesthesiologists. Indeed, I would estimate that fewer than 10 percent of the country’s anesthesiologists are compensated *either* under a salary or percentage arrangement.

Thank you very much.

Senator TALMADGE. Thank you very much for your helpful and constructive statement.

Senator DOLE?

Senator DOLE. Just briefly, of course, I share your view with reference to the statement about the Secretary. I think it raises again the spectre of inaccuracy, for reporting payments under programs were not too accurate, and he promises to be accurate next year and maybe he can also clarify the statement made about your association, since you are opposed to that.

You say professional liability premiums are as high as \$18,000 annually. Are you suggesting \$18,000 as a minimum malpractice payment?

Dr. AMENT. No. The average malpractice insurance premium is, at the present time, \$7,500. In some areas, anesthesiologists, particularly in the Midwest, are paying considerably lower than that, despite the fact that they are in a high-risk category. If you will note, in that statement, I refer to large metropolitan areas. The \$18,000 figure comes from New York City. The \$30,000 figure comes from a part of California. In some parts of California, it is even higher. The metropolitan areas are the areas in which the malpractice situation is most acute.

Senator DOLE. What is it in Buffalo?

Dr. AMENT. In Buffalo it is about \$5,600. The upstate area runs approximately a third to a half of the metropolitan area.

Senator DOLE. That does not give us a totally objective figure, where the highest figure is given for the cost. I assumed it was not that high.

What is the average income for an anesthesiologist? According to the previous testimony, they are quite well-paid.

Dr. AMENT. I would have no way to give you such a figure. We have never done an economic survey on anesthesiologist, the kind of surveys that medical economists have done. My own feeling is that there is a certain built-in error, just in the method of collection. I really could not give you a figure.

Mr. SCOTT. In the letter to Secretary Califano, referred to by Dr. Ament, there is a reference to a study by an independent consulting firm to HEW on the compensation, on a salary basis, or percentage basis, leaving aside the fee-for-service basis, of the three specialties known as hospital-associated.

The average earnings, admittedly, on a small statistical basis, of the anesthesiologist on a salaried basis was \$62,300 a year and on a percentage basis was \$87,400 per year.

As we pointed out in our letter, an anesthesiologist on a percentage basis assumes all or many of his costs of practice which would be paid for by the hospital under a salary arrangement. It is our own belief, based on HEW's own figures, at least on the basis of this study, there is not a substantial difference for the anesthesiologist who practices on a percentage basis rather than on a salary basis.

Senator DOLE. Would it be fair to say that you do not share the views expressed by the previous witnesses, the anesthetists?

Dr. AMENT. No, we do not.

Senator DOLE. There is total disagreement?

Dr. AMENT. Just about.

Senator DOLÉ. That is hopeful.

The nurse anesthetists have asked that we amend the legislation to mandate the only other person to be recognized as performing anesthesia services be a certified registered nurse anesthetist.

Do you have any objection to such an amendment?

Dr. AMENT. Yes; I certainly do. There are programs at the present time, both at Emory University and Case Western Reserve, and these programs will probably be approved by the American Medical Association for anesthesiologist assistants at baccalaureate and master's levels. Restriction of services to nurse anesthetists (other than anesthesiologists services) would preclude these individuals from being able to be a part of the anesthesia care team.

I do not believe that such restrictions should be initiated. We have concerns about the educational programs which are not autonomous from the political and economic organization of the AANA. We have concerns about the quality of the product that comes out of their 18-month school of education, which is not an academic program. As a matter of fact, they were just recently turned down for accreditation status by the Council on Post-Secondary Accreditation. So at the present moment, there are many questions regarding the entire field of nurse anesthesia, and I believe that it would be an error to restrict the law in such a way that it would give this organization a mandate.

As a matter of fact, in order to retain certification, the organization requires membership, which may well be in violation of the antitrust laws.

Senator TALMADGE. Thank you, Senator.

Senator Curtis?

Senator CURTIS. No questions.

Senator TALMADGE. Ms. Ecklund, in all fairness now, we would like to have you respond to Dr. Ament's last comments so we can make that a part of the record so that this controversy can be elucidated in its entirety in the record of this hearing.

Thank you very much, Dr. Ament, for your constructive suggestions. Thank you, sir.

[The prepared statement of Dr. Ament follows:]

STATEMENT OF RICHARD AMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

My name is Richard Ament, and I am here to present testimony on S. 1470 on behalf of the American Society of Anesthesiologists (ASA). I am currently the president of that society, which is composed of approximately 11,000 physicians actively engaged in the practice of anesthesiology. I am also a practicing anesthesiologist in Buffalo, New York, and clinical professor of anesthesiology at the State University of New York in Buffalo.

ASA's position on S. 1470 is straightforward. With only a few minor exceptions, ASA favors those portions of the bill which particularly impact on the practice of anesthesiology. It is a strong bill, and is accurately directed at a few persistent trouble spots in Medicare reimbursement. The "exceptions" which ASA takes to the bill are not directed at the manner in which S. 1470 seeks to accomplish needed reforms. Rather, ASA's concerns are with particular language presently used in the proposed legislation which ASA feels will later prove to be troublesome or counterproductive. This language could be clarified either in the statute itself (the preferable solution, ASA believes) or in the Committee Report.

Having announced that ASA favors S. 1470, and that virtually all of the changes which it would like to see made are changes of wording rather than of meaning, I will now discuss the one true change in the legislation which ASA would like to see. ASA would like to have reinserted in S. 1470 a provision similar to Section 23 of S. 3205 (the predecessor to S. 1470), which would require state Medicaid programs to reimburse physicians at a rate not less than 80% of the reasonable charge for such service as determined by Medicare. We are informed that this provision was deleted because some physicians felt that the "minimum" would in effect become a "cap" on Medicaid fees. Frankly, as far as anesthesiologists and most Medicaid anesthesia patients are concerned, this would be wishful thinking. As best I have been able to determine, most Medicaid programs now pay anesthesiologists only 40% of the reasonable charge as calculated by Medicare. (And, for anesthesiologists, even the Medicare "reasonable charge" is often unrealistically low, since Medicare reimbursement is based on charges submitted during the last complete calendar year prior to the present fiscal year—a lag of 1–2 years—and is subject to an economic index limitation. Thus, Medicare payments do not reflect the astounding increases in malpractice premiums which have occurred in many areas during the past one to two years.)

As a result of the low Medicaid reimbursement schedules, many anesthesiologists are being forced to consider refusing to accept Medicaid patients. In many instances, the Medicaid reimbursement rate does not even cover the anesthesiologist's direct cost of doing business, a cost which, of course, includes extremely high and ever-escalating malpractice premiums. In the large metropolitan areas, for example, anesthesiologists' professional liability premiums are as high as \$18,000 to \$30,000 annually. Thus, since anesthesiologists personally perform on the average 950 to 1,000 cases per year, their malpractice premium cost averages \$18 to \$30 per procedure. Medicaid reimbursement frequently does not cover this cost. At one Pittsburgh hospital, for example, the average reimbursement under Medicaid is \$18 per case. In addition, an unrealistic reimbursement ceiling ranging from \$40 in Pennsylvania to \$100 in several other states has been placed on Medicaid reimbursement. In those states, providing anesthesia care for complex and lengthy procedures, such as craniotomies and open heart operations of six to twelve hours duration, penalizes the anesthesiologist most severely. Furthermore, the fact that a higher incidence of malpractice actions are attributable to Medicaid patients increases the reluctance of the physician to care for these patients at these unreasonably low levels of compensation.

While anesthesiologists who have relatively few Medicaid patients can and will in all probability continue to subsidize those patients, as they have done for years, such a subsidy is impossible for anesthesiologists practicing in hospitals where a large percentage of the patients are Medicaid patients. In those hospitals, anesthesiologists will not be able to afford to practice, and anesthesiologists' care will become unavailable. The implications are clear. Despite the mandate of Title Nineteen that each state Medicaid program provide high quality care to Medicaid patients as a prerequisite to receiving federal funding, such care has already become unavailable in some areas simply because the State programs have consistently refused to pay for it. A specific provision mandating minimum payments under Medicaid is now necessary to ensure that the provision of quality medical care under Title XIX does not become simply a hollow promise.

I would now like to point out two sections of S. 1470 which ASA believes should be clarified. Our views on these two sections coincide with those of the Society of Academic Anesthesia Chairmen (SAAC), an independent organization of anesthesiologists engaged in medical school and residency education in anesthesiology, and I am authorized to make these comments on SAAC's behalf as well as ASA's.

It is our understanding from members of the Senate Finance Committee staff that the actual intent of the sections in question coincides with our suggestions. However, ASA and SAAC believe that to avoid difficulties of interpretation in the future, the Committee should either clarify the language in the sections, or insert into the Committee report language specifically indicating the Committee's intent.

1. PART B REIMBURSEMENT TO EDUCATORS

Section 12 of S. 1470 amends the definition of physicians' services to exclude services which a physician performs "as an educator, an executive, or a researcher". This is generally in accord with present BHI practice and with the policies underlying Part B reimbursement. Part B of Medicare provides supplemental medical coverage only to those eligible persons who choose to participate and who pay monthly premiums for their coverage. As both an accounting and an equitable matter, Part B reimbursement should be provided only for those services actually received by the particular patient who has obtained Part B coverage. The cost of services whose sole purpose is to teach other physicians or to provide for the smooth functioning of the hospital should be borne either by *all* the patients who use the hospital or by the teaching institution itself. Conversely, a specific patient care service should be reimbursed by the patient who receives that service. This is true whether or not an intern or resident learns from watching, or performing part of, that procedure. Otherwise, virtually all surgical and anesthesia care given in teaching hospitals, which include some of the finest hospitals in the country, would be given "free" to Medicare and private patients alike, for the most efficient, and the dominant, means of teaching surgical and anesthesia residents and interns is in the operating room. Denying reimbursement in this type of teaching setting would seriously impair the ability of the hospitals to train new physicians in these specialties.

I have been assured by the staff of the Senate Finance Committee that this is not an intended result of S. 1470. Instead, in S. 1470, the term "services performed as an educator" is intended to refer only to services performed in a classroom setting, not to individual patient care services which also are used to teach. To clarify this intention, ASA and SAAC recommend that the term "physicians' services" exclude only those services that a physician may perform as an educator *when such educational function is not performed simultaneously and in connection with the personal performance or personal direction of an identifiable patient care service*. In the alternative, language specifying this intent could be inserted in the Committee Report. (Suggested language is attached to my statement.)

2. ANESTHESIOLOGY SERVICES

Section 12 of S. 1470 also states that "in the case of anesthesiology services", a procedure is "personally performed in its entirety" (and hence entitled to full reimbursement under Part B) when the physician performs certain specified activities. These activities are entirely reasonable and appropriate when the anesthesia services are administered to facilitate surgery, obstetric delivery, and the like. However, anesthesiologists now perform a variety of services outside the operating room. For example, anesthesiologists render extensive services in pain therapy clinics, intensive care units and respiratory therapy clinics. It would be quite impossible for those services to include the activities specified in Section 12. For example, one activity listed is personal participation in "induction" and "emergence". Those terms are inapplicable to respiratory therapy. And indeed, staff members of the Senate Finance Committee have assured us that the listed activities are not intended to apply to respiratory therapy and other anesthesia services rendered outside the operating room.

However, we have found in the past that unless such intentions are embodied in the statute or in the Committee Report, problems do arise. Thus, ASA suggests that the listed activities refer only to "anesthesiology services, *where anesthesia is administered to facilitate surgery, obstetric delivery, or special examinations.*" Again, although ASA and SAAC would prefer a change in the statutory language, this result could also be accomplished through language in the Committee Report. (Suggested language is attached to my testimony.)

I would also like to confirm ASA's understanding that Section 12 of S. 1470 permits full Part B reimbursement to an anesthesiologist who performs each of the activities specified in that section so long as he is not responsible for the care of more than one other patient when he performs the most critical of those activities (namely, personal participation in the most demanding procedures in the anesthesia plan; following the course of anesthesia administration at

frequent intervals; and remaining physically available for the immediate diagnosis and treatment of emergencies). Thus, an anesthesiologist who is assisted by nurse anesthetists or other nonphysician personnel may receive full reimbursement for each patient whose anesthesia he directs, so long as he does not direct the administration of anesthesia to more than two patients during the enumerated critical portions of the anesthesia plan. (If the anesthesiologist is responsible for more than two patients, but no more than four patients, he will be reimbursed at one-half of the Medicare-determined reasonable charge for each patient.)

This provision will permit anesthesiologists to delegate the more routine portions of the anesthesia plan to trained nonphysician personnel without incurring a financial penalty for so doing—an important result given the fact that there are simply not enough anesthesiologists in this country to provide all needed anesthesia services. By mandating Medicare reimbursement where an anesthesiologist does effectively utilize his time and skill, this section will both lower anesthesia costs in the long run and make available the skills and knowledge of anesthesiologists to maximum number of patients.

In making these comments, however, I am constrained once more to emphasize to the Committee the fact that in terms of optimal medical care, there is no substitute for the one-to-one relationship between anesthesiologist and patient. ASA's support for those portions of the bill which contemplate reimbursement in another context—that is, where the anesthesiologist directs care provided by nonphysicians under his responsibility and control—rests upon the recognition that in many communities, there are insufficient anesthesiologists to provide this optimal form of care. In these situations, we believe, the best practical solution is to encourage the anesthesiologist where possible to assume a medical direction function, so that his medical skills are available to the maximum number of patients consistent with sound medical care for each.

Finally, ASA would like to comment upon Section 15 of S. 1470, which is entitled "Use of approved relative value schedules." This section sets up a procedure for HEW to establish a system of procedural terminology and of relative values which would provide a basis for the reimbursement of physicians by Medicare. Most significantly from ASA's viewpoint, this procedure explicitly provides for the participation of physicians, through their medical societies, in the process of determining relative values. This provision, while it falls far short both in philosophy and methodology from that advocated by ASA, is nonetheless a step in the right direction. Quite apart from its recognition of the constitutional right of physicians to petition the government to communicate their ideas and to protest injustices and outright errors in the method by which they are reimbursed, this provision accomplishes a very practical result. For as government carriers and private insurance companies have found over and over again, it is totally impractical to manage a health care delivery system without establishing channels of communication and cooperation between the administrators of the plan and physicians. In short, it is impossible to effectively administer that which you do not understand. A year or two ago, for example, the Bureau of Health Insurance promulgated regulations which provided Medicare reimbursement only for local anesthesia for cataract surgery, unless special justification in writing was provided for the use of general anesthesia. Reimbursement for cataract operations would no longer be generally provided for the services of a surgeon's assistant or, as a practical matter, for the services of an anesthesiologist. Because of the increasing average age of our patients and the frequency of cataracts in the elderly, both ophthalmologists and anesthesiologists were justifiably concerned. An increased number of elderly patients with heart disease, high blood pressure, and chronic lung disease are requiring cataract surgery. Even if they do not receive a general anesthetic, they benefit from the intravenous sedation, oxygen by nasal cannulae, and constant electrocardiographic and respiratory monitoring that the anesthesiologist provides. Thus, it was clear that BHI's reimbursement policies—which failed to reflect valid medical needs—would adversely and seriously affect the quality of medical services rendered to the elderly. These medically inappropriate regulations were finally withdrawn—but only after a combined effort on the part of the national societies representing anesthesiologists and ophthalmologists.

As this example illustrates, to understand the health care delivery system, it is most efficient to utilize—not to ignore—the combined knowledge of physicians. Using this accumulated experience and expertise of physicians is quite clearly the fairest, quickest, and consequently the *cheapest* way to administer a health care reimbursement system. For this reason, the input of organized medicine has been provided for, and effectively utilized, in virtually every health delivery system throughout the world. And for this reason also, insertion of a provision such as Section 15, providing for the input of physicians into the determination of reimbursement methodology at the earliest stages of the development of that methodology, is a most appropriate provision in a bill such as S. 1470 which seeks to streamline, reform, and increase the cost-effectiveness of the far-reaching Medicare system.

Thank you.

COMMITTEE LANGUAGE: PART B REIMBURSEMENT TO EDUCATORS

Section 12 amends the definition of "physicians services" contained in Section 1861(a) of the Social Security Act to exclude those services which a physician performs "as an educator, an executive, or a researcher". This provision is generally in accord with present B.H.I. policy and with the policies underlying Part B reimbursement. Under this section, Part B reimbursement is provided only for those services actually received by a particular patient who has obtained part B coverage. The cost of services whose sole purpose is to teach other physicians, to provide for the smooth functioning of the hospital or to carry out research should be borne either by *all* the patients who use the hospital (in the case of Medicare patients, such costs would be proportionately allocated under Part A) or by the teaching institution itself. Particular patient care services, on the other hand, should be reimbursed by the patient who receives them. This principle would apply whether or not an intern or resident learns from watching, or performing part of, those services. Thus, Section 12 permits reimbursement to a physician under Part B for those specific patient care services which he performs or directs whether or not those services are also used to teach. But it denies reimbursement for those teaching, administrative and research services which do not provide a direct patient care service.

COMMITTEE LANGUAGE: ANESTHESIOLOGY SERVICES

Section 12 states that "in the case of anesthesiology services", a procedure is "personally performed in its entirety" (and hence entitled to full Part B reimbursement) when the physician performs certain specified activities. These activities refer to certain steps which should be taken whenever anesthesiology services are administered to facilitate surgery, obstetric delivery, or special examinations. They do not, of course, refer to various services which an anesthesiologist may perform outside the operating room, such as respiratory therapy, pain therapy, intensive care, etc. Reimbursement under Part B for those services should be provided in accordance with general Part B reimbursement principles and policies.

Senator TALMADGE. Ms. Ecklund, if you could submit that for the record?

Ms. ECKLUND. We will.

[The following was subsequently supplied for the record:]

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS,
Chicago, Ill., June 20, 1977.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee, U.S. Senate,
Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: We are greatly interested in the statements made by the witness representing the American Society of Anesthesiologists who followed us on Friday, June 10, before your subcommittee. We are responding to your invitation to submit for the record any comments we wished to make on the statements made by Dr. Richard Ament. This letter is for that purpose, and we would appreciate it being made a part of the record.

We wish to mention that we appreciated the suggestion made to us by the staff counsel, Mr. Jay Constantine, some weeks ago, to the effect that it would be helpful to the staff, and certainly everyone concerned if representatives of our Association and of the American Society of Anesthesiologists got together with the staff to discuss various issues in a very informal and frank way. We could see the value of such an exchange and were warmly receptive to it. Thus, we offered to host a dinner for representatives of the two associations along with the staff of the Committee. We were keenly disappointed when the anesthesiologists refused the invitation to participate, giving for an excuse that their legal counsel had advised against it. Their reason, frankly, appeared to us as being without foundation and we wonder at their unwillingness to make statements to the staff of the Committee in our presence so that there might be an opportunity for some thoughtful discussion of them. Thus, as you know, we had a discussion with the Committee staff but without the anesthesiologists being present.

In regard to your invitation to submit for the record any comments on the statements made by Dr. Ament we offer the following:

I. In response to a question regarding the role of the nurse anesthetist, Dr. Ament made the point that the nurse anesthetist must practice under the direct supervision of a physician and he referred, in particular, to the State of Georgia in this respect. There is no question as to the relationship of a nurse anesthetist to the physician, and we have always stated that this fact is recognized under the law.

However, Dr. Ament failed to mention very importantly that "this physician" need not be an anesthesiologist. State laws do not require the presence of an anesthesiologist, and, as we have stated in our testimony, in many, many instances no anesthesiologist is present or available. In such situations the nurse anesthetist is always working under the supervision of a physician but it is the surgeon. And, as we have also pointed out in testimony, very often in such cases the surgeon does not presume to be authoritative with respect to the anesthetic administered but relies on the experience, training, and proficiency of the nurse anesthetist.

In this respect we would also like to comment upon the role of supervision where the anesthesiologist is expected to be and can be present. We believe one of the significant improvements which could be brought about by the amendments which we have recommended in recognition of nurse anesthetists is a clarification of the term "supervision." There are instances where this term has very real meaning and where a Board Certified anesthesiologist works with nurse anesthetists in a helpful and collaborative role. However, there are far too many examples where the term "supervision" is meaningless and is simply used by the anesthesiologist as a basis for financial gain. In discussions with staff of the Bureau of Health Insurance of H.E.W., they have indicated to us that defining the term "supervision" is very difficult and, as a result, they are aware of substantial economic waste and abuse.

II. A question was asked with respect to a clarification of terminology, and the particular question was whether Dr. Ament considered the nurse anesthetist as "an equivalent colleague." Nurse anesthetists are not physicians and we have always made this quite clear.

In terms of the qualifications of nurse anesthetists we wish to point out that they provide the anesthetic for patients undergoing the most highly specialized surgery such as heart surgery, transplants, etc., and, in such instances, of course, the nurse anesthetist is working in the large medical teaching centers. Just as there is no specific evidence or measures as to the quality of the anesthesia provided by physicians, there is none either with respect to the quality of services provided by nurse anesthetists. We can only refer you to the situation in which nurse anesthetists function and specifically perhaps to the Armed Services where we are sure you will find that nurse anesthetists are well recognized in terms of their ability and the quality of their work.

There have not been any substantial and extensive studies on the quality of anesthesia. In our testimony we stressed our belief in the need for such a national study and recommended, in fact, that the Committee and the Congress instruct H.E.W. specifically to see that such a study be undertaken without further delay. Such a study would be helpful to the field of anesthesia and certainly would be in the best interest of patient care. The study should be performed by an independent research team.

We are disappointed that Dr. Ament did not support our recommendations to the Committee that a study of quality of anesthesia be undertaken. We are particularly concerned that the bill (S. 1470) contains language (which Mr. Constantine said was supplied by the anesthesiologists' leadership) which would not support good quality anesthesia practice and in this regard, we made several recommendations to the present language which we believe to be essential.

III. The matter of basic education and preparation of nurse anesthetists was also raised by Dr. Ament in the questioning. Dr. Ament in his answer to the question appeared to suggest that the American Society of Anesthesiologists had great concerns about the education of nurse anesthetists. Our national association has a very strong program directed towards the quality of the education process of students undertaking graduate training in anesthesia. We wish to state very clearly that we see no reason to apologize for the education received by nurse anesthetists. In general, their education, knowledge, and ability with respect to the basic sciences learned first as graduate nurses is certainly valid.

We have worked very closely with the United States Office of Education, Department of Health, Education, and Welfare, and the approval of the program of accreditation for schools of nurse anesthesia is given by this department of the United States Government. Just recently the accreditation program was reviewed by the Office of Education and once again the representative of the anesthesiologists appeared before the review committee and raised numerous questions about the quality of the education, all of which were considered thoroughly by the review committee appointed by the Office of Education and rejected. We now feel impelled to conclude that this continued effort on the part of the anesthesiologists to denigrate the quality of education of nurse anesthetists has little to do with any documented concern for their education or for protecting the public. Rather, it is directed by a strong desire to control and dominate nurse anesthetists by being in a position to control their education. We state very strongly our belief that such control is not in the public's interest, and we do not intend to submit to it.

IV. Dr. Ament stated that the Council on Post secondary Accreditation (COPA) had recently denied AANA's request for accreditation. This simply is not true. COPA is a national non-profit organization whose purpose is to support, coordinate and improve all non-governmental accrediting activities conducted at the post secondary educational level in the United States. It is the first organization that was created to serve as the national voice on behalf of all institutions and associations concerned with non-governmental accreditation. On October 24, 1976 the AANA Council on Accreditation submitted an application for recognition by the Council on Post secondary Accreditation. Action on this application has been delayed pending receipt of additional evidence of compliance with certain COPA provisions for recognition. A revised petition will be submitted to the COPA Board on, or before September 1, 1977 and representatives of the AANA Council on Accreditation will make an oral presentation before members of the COPA Board on October 12, 1977. For Dr. Ament to state that the AANA Council on Accreditation was denied recognition by COPA is simply a misstatement of fact.

In addition, Dr. Ament seemed to suggest that the Council on Accreditation was under the control of the Association and that this somehow was an insidious relationship. The autonomous nature of the Council on Accreditation was insisted upon by the U.S. Office of Education, and we have thus moved toward strengthening its independence. We might point out that several representatives of the American Society of Anesthesiologists participate as members of this accreditation council.

We are sure you will agree with us that it is a little odd for a physician to appear overly critical of a national association instigating various processes to improve a given field of practice. Without doubt one of the great contributions of the American Medical Association to the whole field of health care resulted from its taking the initiative in past years to see that a variety of efforts were made to establish standards and quality measures for various fields of practice. We take great pride in the fact that our national association, which in fact initiated and subscribes to the whole process of accreditation, has developed the accreditation council to the point where it can and does function as an autonomous body. It is worth pointing out also that as a result of this effort, a basic two-year program of graduate education is strongly encouraged and new programs will not be recognized unless they have a two-year course of study.

V. A reference was made by Dr. Ament to the physician extender in anesthesia. This reference was made to substantiate his criticism of our recommendation that S. 1470 be amended so that the "qualified individual" mentioned in the legislation would have to be a nurse anesthetist. Inasmuch as the nurse anesthetist is the only qualified individual by training, other than the anesthesiologist, whose services are available nationwide, we stand by our recommendation.

There are several shortcomings related to the physician extender which we wish to point out. We believe it is misguided to think that physician extenders will for long accept only a salaried basis of reimbursement. Thus, we believe it is a mistake to think that physician extenders will work in situations where the anesthesiologist receives fee for service and the physician extender will be denied fee for service and will be content with a salary arrangement.

The physician extender cannot practice individually and, legally, he can only perform when he is working with the anesthesiologist. In other words, we believe the anesthesiologist will have to be present. In a large number of small hospitals no anesthesiologist is available today nor are they likely to be available in the future. Therefore, a physician extender is not in a position to function at these hospitals.

From an economic standpoint we would point out that there is no evidence that the use of physician extenders has resulted in any decrease in the costs of health care. In fact physician extenders may have increased the cost of health care.

We would stress that we do not consider nurse anesthetists as physician extenders, and we do not wish to be so classified. Nurse anesthetists, in many situations, function exactly as the anesthesiologist would function. In other words, only a physician may be substituted for those services provided by a nurse anesthetist.

The economics of the field anesthesia and the income of anesthesiologists were also discussed by Dr. Ament. In our letter to you of August 21, 1975. Mr. Chairman, we pointed out that, from the income figures which were available, it appeared that the incomes of anesthesiologists "will approximate five times those of the nurse anesthetists for delivering anesthesia services." We believe, from information received and not on the basis of any studies which we have made, that Dr. Ament's statement about the income of non-salaried, free lance anesthesiologists was quite understated. In the conference called by former President Ford on the impact of inflation in health in 1974, a background paper developed by H.E.W. contained the following statement: "The greatest increase in net income in the five-year period (1968-1973) was for the specialties, with the highest incomes with anesthesiology registering the largest gain—44 percent." Recently we sought to obtain statements from nurse anesthetists with respect to specific situations, and we attach herewith one such statement which we have received and which indicates an income for anesthesiologists in the area of \$150,000. From the knowledge of nurse anesthetists, as they have told us, such an income level is not at all unusual.

Dr. Ament also suggested that anesthesiologists were confronted with all of the increased costs of practice faced by practicing physicians generally. From our knowledge of the field this is not at all the situation. In fact, anesthesiologists traditionally do not have an office and generally do not employ nurses or other staff. In most instances the services, staff and facilities required by anesthesiologists are furnished to them by the hospitals in which they practice. We see no basis for attempting to justify increases in the cost of services rendered by anesthesiologists because of the greater costs encountered by physicians in general and in private practice in particular. Specifically, for each dollar charged by anesthesiologists the likely net income is substantially greater than that of most practicing physicians.

Several of the matters commented upon in this letter were not a part of our testimony, but, as they were brought up as part of the testimony of Dr. Ament and are thus a part of the printed testimony of the hearings, it is essential that we respond to the opportunity for comment which you suggested to us in order that the record be as factual and complete as possible.

If you wish us to submit any additional information on any of the matters covered either in this letter or in the testimony which we presented, please let us know.

Sincerely,

RUTH E. ECKLUND, CRNA,
President.

Enclosure.

KOSCIUSKO CO. ANESTHESIA,
Warsaw, Ind., May 5, 1977.

A.A.N.A.,
 111 E. Wacker Drive,
 Chicago, Ill.

Attn: Ms. Nancy Fevold, Deputy Executive Director.

DEAR MS. FEVOLD: In answer to your letter of April 20th concerning exploitation of nurse anesthetists by M.D. anesthesiologists, I feel I can reflect on the situation in Kalamazoo, Michigan. The two major hospitals in Kalamazoo are Bronson with twelve operating rooms and Borgess with eight operating rooms. The anesthesia coverage consists of a group of eleven M.D.'s and eighteen nurse anesthetists. The nurse anesthetists do 90% of the anesthesia and at any given time three of the M.D.'s are on vacation, leaving three M.D.'s per hospital for so-called supervision.

In January of 1976 the anesthesiologists dropped their liability malpractice coverage because they felt that since the C.R.N.A.'s were doing 90% of the anesthesia, the C.R.N.A.'s coverage would be adequate. Starting salaries for C.R.N.A.'s was approximately \$16,500.00 to \$21,000.00 maximum. The total income of Kalamazoo Anesthesiology was in excess of \$2,000,000.00, but the total paid to C.R.N.A.'s was about \$360,000.00, leaving approximately \$150,000.00 per man for the anesthesiologists who did little anesthesia and had no liability coverage. Any inquiry for anesthesia practice at Bronson or Borgess is referred to Kalamazoo Anesthesiology P.C., and the hospital medical by-laws require M.D. supervision. Also there is no free lance C.R.N.A. anesthesia allowed in town. We feel that this is a prime example of exploitation of one profession by another and that our proposals on April 4th making the C.R.N.A. an independent anesthesia practitioner would confront the problems directly. I have first hand knowledge of this information as I was one of the C.R.N.A.'s in question for a period of five years.

I hope this example will help Mr. Williamson project the true situation of M.D. ghost billing and the exploitation of C.R.N.A.'s.

Thanking you I am,
 Yours very truly,

(Mrs.) MARILENE BEARDSLEE, C.R.N.A.

Senator TALMADGE. The next witness is John Filer, Chairman, Aetna Life and Casualty Co. on behalf of Insurance Association of Connecticut.

STATEMENT OF JOHN H. FILER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, AETNA LIFE AND CASUALTY, ON BEHALF OF THE INSURANCE ASSOCIATION OF CONNECTICUT; ACCOMPANIED BY BURTON E. BURTON, SENIOR VICE PRESIDENT, GROUP DIVISION, AETNA

Mr. FILER. Mr. Chairman, my name is John Filer and I am chairman and chief executive officer of Aetna Life and Casualty Co. With me on my right is Mr. Burton, senior vice president and head of our group division of Aetna. We are appearing here today on behalf of the Insurance Association of Connecticut, which is a trade association of Connecticut domiciled insurance companies.

The companies currently write 30 percent of the commercial group health insurance which is sold in the United States. Our member companies, as leading members of the Health Insurance Association of America, support the testimony of the HIAA given earlier this week.

Our comments today will deal primarily with those elements with S. 1470 that are aimed as controlling hospital costs, a subject of direct interest to our companies as insurers and employers, and to our policyholders around the country.

We believe there is a need for immediate legislative action to help control hospital costs. S. 1470 takes a number of steps in the right direction. We believe the establishment of uniform financial reporting, the concept of a classification system for hospitals, comparisons between like hospitals to promote competition and efficiency, and the use of incentives and penalties all are elements which can lead to effective hospital cost control. We also strongly support the payment of funds to promote the closing or conversion of underutilized facilities. Likewise, we support tying reimbursement for capital expenditures to approval by the designated planning agency.

We would, however, offer the following observations and suggestions which we believe are crucial to the success of S. 1470 as a long-term solution to the hospital cost-control crisis.

First, the program should control hospital costs for all patients rather than applying only to medicare and medicaid reimbursement. Although the bill provides that hospitals may not increase the amounts due from others to offset reductions under this program, we believe this section is unenforceable.

Second, by limiting controls to routine operating costs and by excluding controls on ancillary services, the program only addresses 35 percent to 40 percent of hospital costs.

Senator Talmadge has, of course, already announced plans to address these first two points, and we support such changes.

Third, by using average per diem cost for routine services as a measurement of efficiency, the bill may encourage hospitals to lengthen average stay or change patient mix so as to reduce per diem costs.

Fourth, our major concern is that the bill does not provide for prospective review of hospital budgets and rates. Uniform financial reporting, classification and comparisons of hospitals, and the use of incentives and penalties, are steps which are consistent with prospective rate review. We believe review of overall budgets and rates is a crucial next step in this regulatory process. We believe prospective budget and rate review, exceptions review and many other elements of a cost control system can best be operated at the State level, subject to Federal guidelines. We urge you to include strong incentives for the establishment of State prospective reimbursement systems and to grant exemptions from Federal controls to those States which establish such programs.

Our strong endorsement of State prospective reimbursement is based primarily on three things: (1) The need for close coordination between cost control programs and the planning, certificate of need and utilization review activities now being conducted at the local level; (2) the need for adequate input into the cost control process by the parties affected—providers and insurers as well as consumers; and (3) our experience in Connecticut and with Government Research Corp.

The Connecticut commission on hospitals and health care was established in 1973 and charged with the administration of the State's certificate of need law, with the review of all operations of institutional services, and with approval of hospital rates and budgets. Connecticut hospital prices had been rising at or above the national average, but in fiscal year 1975 and 1976, the Commission held the rate of increase in Connecticut hospital charges for individual services to 8.3 percent and 9.6 percent respectively.

Because of increased utilization of services, the rate of increase in total hospital revenues in Connecticut was approximately 16 percent in fiscal 1975 and 1976. This is still below the national average of 19.5 percent in 1975 and 22.3 percent in 1976. The commission has saved Connecticut consumers an estimated \$35 million since 1973, and it has done so without adversely affecting the quality of care.

Of course, Connecticut has not been without its problems. The commission has recently been concentrating its efforts on controlling total hospital revenues, recognizing that price control is not necessarily cost control. Since 1973, it has also become apparent that more procedural safeguards were needed in the rate review process, and that the commission needed the expertise of third party payers. These changes have been made under recent legislation.

Since 1973, the process of hospital cost control in Connecticut has matured from a regulatory point of view. A Federal program which sets guidelines for prospective reimbursement operated at a State level could benefit from such refinements.

Along with representatives of hospitals, employers, unions, State regulators and third party payers, we recently participated in an 8 month review and analysis of prospective reimbursement which was sponsored by Government Research Corp. Although the final work product does not represent a system which the participants as a group would necessarily recommend or support, we believe it is a workable and effective proposal, and we will submit a copy of the report for the record.¹ Essentially, the proposal suggests prospective reimbursement operated under Federal standards, but run at the local levels by State commissions.

In conclusion, we urge you to enact a cost control program which applies to all patients, and which places equal emphasis on quality of care, on hospitals' need to be adequately reimbursed for all legitimate elements of cost, and on the public's need to have the rate of increase in hospital costs controlled.

State prospective reimbursement can help accomplish this goal. The concept has been put to the test in Connecticut in Maryland and in a number of other States. It offers the local expertise and knowledge which a Federal system could never achieve, is capable of a more sophisticated in-depth look at particular hospital operations than a Federal system, and offers the flexibility needed to become an extremely effective regulatory process.

We offer you and your staff any assistance we can provide.

Senator TALMADGE. Thank you, Mr. Filer. I want you to know how much we appreciate the support which you have expressed for S. 1470. I did, however, want to respond to two of the concerns expressed on page 2 of your statement.

You say that by using average per diem costs for routine services as a measure of efficiency that the bill may encourage hospitals to lengthen average stay or change patient mix so as to reduce per diem cost.

The bill does provide where a hospital deliberately alters its patient mix to do exactly what you say, reimbursement would be adjusted to

¹ The report referred to will be made a part of the official committee file.

reflect any manipulation. Insofar as length of average stay, the answer to any artificial game-playing along those lines is effective professional review.

As a practical matter, based upon our study, the differences in average stay, length of stay, do not seem to particularly affect the adjusted per diem cost.

The effect of shorter stays for a given illness is reflected more in the per diem cost of the services such as laboratory, pharmacy and X-ray. You have indicated that your major concern is that the bill does not provide for prospective review of hospital emergency rates. While we may not specifically provide for that type of review, the bill does authorize an exception where a State system, does a better job. Thus of the system in Connecticut which you refer to and Maryland which you refer to, results in less costs that would otherwise occur under the particular reimbursement mechanism, we would accept that.

Senator Curtis?

Senator CURTIS. I have no questions.

Senator TALMADGE. Thank you very much for your contribution, Mr. Filer.

The next witness is Dr. Richard C. Reba, president, American College of Nuclear Physicians; accompanied by Dr. Eugene L. Saenger, chairman, governmental affairs commission and Kenneth L. Nicolas, executive staff.

It is a pleasure to see you again, Doctor.

STATEMENT OF RICHARD C. REBA, M.D., PRESIDENT, AMERICAN COLLEGE OF NUCLEAR PHYSICIANS; ACCOMPANIED BY JOHN DRING AND KENNETH L. NICOLAS, EXECUTIVE STAFF

Dr. REBA. I am Richard C. Reba, a physician and a director of the division of nuclear medicine at George Washington University, and I am currently the president of the American College of Nuclear Physicians. With me is Mr. John Dring and Mr. Kenneth Nicolas of the executive staff of our college.

The statement that we are making to you is on behalf of the American College of Nuclear Physicians which represents physicians in a new and growing specialty now recognized by various branches of the Federal Government, the Departments of HEW, DOD, as well as organized medicine.

The specialists of this discipline are certified in nuclear medicine by the American Board of Nuclear Medicine, in nuclear radiology by the American Board of Radiology and in nuclear pathology by the American Board of Pathology.

The practice of nuclear medicine includes procedures by which radiopharmaceuticals are administered to patients and images then obtained by nuclear detectors and various electronic devices. These procedures thereby provide an image of the distribution of the labeled drugs and thus aid in medical diagnosis.

In addition, there are tests of function of organs and tissues where radioactive drugs are administered and the flow of these compounds is followed to determine whether or not the organs are working nor-

mally. It is also possible to analyze materials derived from the human body such as blood and excreta to study organ and system function. Furthermore, there is a large and growing field, commonly termed *in vitro* testing, where radioactivity is added to material removed from the human body in order to measure the concentration of important biological materials such as hormones, vitamins and drugs. The field of nuclear medicine encompasses all of these methods as well as the use of radiopharmaceuticals for certain types of therapy.

While the ACNP agrees with and supports the goals of S. 1470 we have several suggestions which we would like to offer concerning the bill.

While S. 1470 preserves the eligibility of radiologists, pathologists and anesthesiologists to be paid by medicare and medicaid on a fee-for-service basis for patient care services when certain criteria are met, the bill does not specifically include nuclear physicians. Section 12(a) (3) on page 32, line 21, should be amended to read "Laboratory diagnostic services," in lieu of "Pathology services," since the specialized *in vitro* procedures performed by nuclear physicians and other specialty areas involved in such procedures, frequently termed radioimmunoassay, do, in fact, represent a consultative service to individual patients within the meaning of section 12(a) (3). The performance of these tests require special competence and constant review and supervision, particularly in difficult cases, and the nuclear medicine physician is intimately engaged in consultation with both patients and their referring physicians.

The nuclear medicine physician as a consultant is required to interpret the special tests which are performed in his laboratory for the referring physician and therefore, participates directly in the care of these patients.

Over the last year, there has been considerable controversy over the use of relative value scales in determining physician reimbursement. We believe that a system of relative values can promote more effective administration of medicare and medicaid, and we support the intent of the bill to provide a means by which such scales may be developed and utilized. However, we are concerned that placing unrestricted decisionmaking authority in the hands of one person—the Secretary of HEW—may not be the best way to achieve this purpose.

We would suggest, instead, that an independent board should be created to accomplish this task. This board should be directed to utilize the expertise of medical societies and colleges in developing relative-value scales that would serve the public while maintaining the high quality of medical services which our country now provides.

Finally, the college would like to note that we oppose the concept of applying a fixed administrative cap on hospital revenue as a means to controlling the cost of Government health care programs. Prospective reimbursement is a more effective tool, since it provides the flexibility which the Government needs in dealing with different types of hospitals.

In general, the ACNP agrees with the substantive proposals of S. 1470 and wishes to commend you for its content. It is our hope that under this bill, as modified, the needs of our important specialty field of nuclear medicine and the needs of the medical profession in general will receive the consideration requested above.

Thank you for your consideration in this important matter. The American College of Nuclear Physicians stands ready to assist you or your staff in any way and we thank you for the opportunity to present our views.

Senator TALMADGE. Thank you, Dr. Reba. It seems to me that you have made a reasonable request and one that can be worked out with staff.

Senator Curtis?

Senator CURTIS. I have no questions.

Senator TALMADGE. Thank you very much.

The next witness is Dr. Thomas G. Dorrity, director of the Association of American Physicians and Surgeons; accompanied by Maurice A. Kramer, assistant executive director, Washington office.

Dr. Dorrity, we are delighted to have you with us.

STATEMENT OF THOMAS G. DORRITY, M.D., DIRECTOR, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS; ACCOMPANIED BY MAURICE A. KRAMER, ASSISTANT EXECUTIVE DIRECTOR, WASHINGTON OFFICE

Dr. DORRITY. Mr. Chairman and Senator Curtis, we appreciate this opportunity to present the views of the Association of American Physicians and Surgeons on S. 1470 which, as we see it, is intended to further extend the bureaucratic grip on the Nation's hospitals. I am Thomas G. Dorrity, M.D., chairman of the AAPS legislative committee. I am a practicing surgeon in Memphis, Tenn. With me is Maurice Kramer, AAPS Washington representative.

The Association of American Physicians and Surgeons is a free, independent, nongovernmental, voluntary organization of physicians who take care of patients. We have been devoting our energies since 1943 to trying to prevent any kind of interference with the freedom of physicians to exercise their best judgment for the benefit of their patients. We may be distinguished from most other nationwide medical organizations by the fact that we are unalterably opposed to Government subsidies, which only the naive do not recognize result in suffocating and brutally destructive bureaucratic regulation and control.

We believe that Government subsidies corrupt and massive subsidies corrupt massively. Members of AAPS are against compulsory political medicine, whether called medicare, medicaid or falsely labeled national health insurance. We are for individual responsibility and freedom, which are the basis for the glorious and noble successes of mankind.

On May 27, Senator Talmadge, announcing these hearings on S. 1470 commented on the alarming report of trustees that the way things are now going, medicare will come up to \$9.5 billion short every year for the next 25 years. And that was calculated on constant 1977 dollars, excluding the factor of inflation. Senator Talmadge said:

There are those who advocate transferring tax money from the Medicare trust fund to the cash-short old-age assistance and disability funds. Under the circumstances, that would be akin to the Federal Government trying to borrow money from New York City. Given the enormity of the medicare actuarial deficit, this is the time to face up to the issue and not to compound the problem.

The Association of American Physicians and Surgeons heartily agrees with Senator Talmadge—up to a point. That point is that we do not believe S. 1470 or anything like it is the proper solution to the twin disasters known as medicare and medicaid. With all due respect to Senator Talmadge, S. 1470 will not solve the financial problems of these programs.

It will simply prolong and intensify them. The reason is that S. 1470 does not—as the Senator wishes—face up to the issue. It seeks to clamp new forms of artificial cost curbs on doctors and hospitals. The spurious reasoning is that they alone are responsible for the calamitous increase in the cost of these programs.

What is wrong with S. 1470 is that it ignores the real villain in this financial mess—the wholly irresponsible deficit spending habits of our profligate Federal Government—a tragic habit for which the Congress must accept considerable blame.

When Members of Congress and the bureaucrats in HEW, the White House, and other executive departments try to solve such problems by blaming someone else, they are simply, in true Machiavellian style, dodging and ducking their own responsibility for the problems and sliding away from the real solution.

The only long-term, permanent solution to the fiscal woes of medicare and medicaid is to abolish both programs and simultaneously, start an honest attempt to stop robbing the citizenry through inflation. Let's quit kidding ourselves and the American people and make a bold and forthright confession of the truth—the real culprit in rising costs of everything is inflation and the real cause of inflation is the financial excesses of the Federal Government.

We know the bleeding-heart liberals who do not care what they do to people as long as they can convince them they are doing something for them, will pretend to be aghast at the suggestion of wiping out medicare and medicaid and will accuse us of callous indifference to human needs.

And to that, we say hogwash. Physicians who take care of the health needs of the American people have more compassion and know more about human needs than any other group, certainly a lot more than the career politicians and bureaucrats who persistently push the Government into programs it has no business being in.

The Federal Government had no business getting into medicare in the first place. It was conceived in error and promoted by fraud. Let me remind this committee that when politicians, bureaucrats and labor bosses were promoting medicare, they argued that most people over 65 were being denied medical care because they could not pay for the care they needed. But Members of Congress were publicly challenged to produce names of elderly people in that situation. It was promised they would get the care they required without charge. Local medical societies advertised free medical care to the elderly, with confidentiality guaranteed, who needed care but felt they could not pay for it.

Out of the 18 million people who were then over 65, a scattered handful sought care from those appeals—and the Members of Congress produced no names.

It will be remembered that the late President Lyndon Johnson pleaded for passage of medicare, promising it would cost no more than

a dollar a month per person. Labor union leaders, who have a vested interest in shoving the cost of health care onto the taxpayers to free up billions in union health and welfare funds for other uses, argued the cost per capita would be less than the cost of a package of cigarettes a week.

So, Congress plunged in, ignoring the warnings of excessive costs from physicians, economists, and private insurance company actuaries. HEW officials said medicare hospitalization alone would cost only about \$900 million the first year, rising in 5 years to a mere \$1.7 billion.

What happened? Government statistics show that hospitalization under medicare the first year cost three times more than HEW actuaries said it would. As predicted by insurance experts and others, costs skyrocketed. Medicare in 1976 cost \$17.8 billion. Medicare and medicaid together cost \$33.1 billion in 1976—an increase of 2,264 percent from 1965. As Senator Talmadge has noted, the estimated cost of these programs for fiscal 1978 will be \$47.5 billion.

Medicare was supposed to be a foot-in-the-door toward full-blown socialized medicine. Remember, the late Aime Forand, speaking in favor of the King-Anderson bill—which became medicare/medicaid—said: “Let’s get our foot in the door and we can expand the program after that.” It turned out to be a mighty big foot that just keeps growing.

And if it costs \$47.5 billion to partly pay for medical and hospital care for the elderly and indigent, is that not foolish and reckless and irresponsible and dangerous to argue that the Nation can afford full-scale compulsory political medicine for everyone, such as is proposed by Senator Kennedy and by the American Medical Association and others?

Honest people with a serious desire to pursue and expose the truth about political medicine should read “Medicine and the State” by Dr. Matthew J. Lynch and Stanley S. Raphael. It is by far the most objective, most searching inquiry ever undertaken into political medicine and its consequences in the countries of Europe which have had the bad judgment to adopt it. “Medicine and the State” is published by the Association of American Physicians and Surgeons. We will be happy to make copies available to the members of this committee, with the hope that you will study it carefully and digest its message completely.

“Medicine and the State” shows conclusively that when government assumes the role of payor and provider of medical care, the quality deteriorates and the cost goes up, most of the time in quantum leaps.

An important aspect of government intrusion into the field of medicine which congressmen have willfully refused to consider is that government is a political organism which by necessity must impose political decisions on the art and science of medicine. Medicine is an art and an individualistic science; government is a paternalistic political entity. The two are incompatible.

The inherent characteristic of government is to tighten its grip on whatever it gets hold of. In the case of medicare and medicaid, the rising cost, for which government is largely responsible, is used as an excuse to take over the operation of hospitals and, at the very least, to further interfere with physicians.

And that, of course, is a political act which directly violates a political promise made by Congress. That is the promise made in section 1801 of the medicare law that the law could not be used to let government officials or employees exercise supervision or control over the practice of medicine or the manner in which medical services are provided or over the administration or operation of any hospital.

But that is the way it is with politics—the promise to do good is too often the precursor of bad deeds.

We find it difficult to understand the surprise and alarm at the swiftly climbing cost of medicare and medicaid when there appears to be no corresponding surprise and alarm at the out-of-control growth of the power-drunk Government here in Washington. No one seems concerned that the dollar that was worth a dollar in 1940 is worth 19 cents because of the theft called inflation or that even the 1967 dollar is now worth only 54 cents. This thievery by officeholders through inflation is performed under the monopoly power of government to regulate the value of money.

No one in Congress or the White House or the bureaucracy is facing up to the appalling fact that the annual Federal deficit has ballooned an astounding 2,442 percent since 1950, that while private spending for health care since 1950 has increased 797 percent, Government spending has spiraled upward by 1,860 percent, that the amount of earnings and income taken away from citizens and spent by Government has grown from 32 percent in 1950 to 53.7 percent today.

A few noisy people who envy the professional and financial success of the majority of physicians or do not like doctors for a variety of other personal reasons, keep shouting about the rising cost of medical and hospital care. We have listened and listened and we just do not hear those voices shouting their indignation that HEW is getting fatter and fatter and fatter at the expense of taxpayers. Make no mistake—these long-suffering taxpayers are growing mighty tired of this kind of misrepresentation here in Washington.

This Congress is being asked to slap a 9-percent ceiling on the yearly increase in income of hospitals. But we have not seen any proposal from the White House or HEW to limit HEW's spending increases to 9 percent a year. And that is interesting because HEW's budget has grown 973 percent since 1960, from \$15.1 billion to an estimated \$162 billion for 1978—and that is an average of 54 percent a year.

Medicare and medicaid have not proved anything, except that when Government tackles something it inevitably runs the cost up without improving it—like Amtrak, the postal service, airlines, food stamps, and other welfare programs. Medicare and medicaid simply have not improved the quality of medical and hospital care for their recipients; they have not made care more available; they have just increased the costs.

The truth of the matter is that S. 1470 is in itself a ringing declaration of Government failure in attempting to control and pay for the provision of medical and hospital care for a portion of the population. It is stirring proof of what happens when Federal bureaucrats presume that they are more competent and capable of providing goods or services than private citizens.

S. 1470 would create a ponderous, tangled and complex structure of procedures for reimbursing hospitals and physicians which would be intended to curb costs. What it would actually do is create an injustice on hospitals and physicians by bludgeoning them for a situation caused by the very Government that is wielding the club. It would add to the bureaucratic cost of administering these programs. And when this program also failed because it was the wrong answer to the problem, some new controls would be imposed.

The Government has proved it is incompetent and incapable of providing, regulating and paying for health care services to the elderly and the indigent. It is time that this Congress courageously faced up to that indisputable fact and made arrangements to abandon these disastrous experiments in governmental intrusion into private affairs where it does not belong.

Before these programs were enacted, U.S. physicians gave more than a billion dollars of free care to their patients every year. They are willing now as they were then to assure that no one in this country is denied needed medical care solely because of finances. We assure you the elderly and the poor will be denied far, far less than they are now if these programs are recognized as abysmal failures and abandoned.

We urge that this committee not pass 1470 but deal with the question of Government interference in medicare and medicaid, where it is doing more harm than good.

Thank you.

Senator TALMADGE. Thank you, Dr. Dorrity. I certainly agree with you on one thing—we ought not to expand further coverage until we can get a handle on the costs that we are expending now.

Senator CURTIS?

Senator CURTIS. I want to say to you, Doctor, in reference to your remarks about inflation and the fact that the chief culprit was unbridled government spending, that you are speaking to receptive ears. The distinguished chairman of this subcommittee, Senator Talmadge, is the author of a constitutional amendment that will compel the Government to go on a balanced budget. He cosponsored mine and I cosponsored his. Mine is slightly different.

He believes that there is much danger in deficit financing. Serious individuals were worried when deficits remained at \$2, \$3, \$4, \$5 billion a year. Now we are talking in terms of \$50 to \$60 billion and it is time to take note; we certainly agree with you. Whether we are talking about hospital expenses or household expenses or anything else, inflation is across the board. The Government cannot escape its responsibilities.

We also believe that, aside from its effect on inflation preventing the continuous rise in national debt, the pay-as-you go requirement will mean good government, because then the Congress will have to consider programs to see which ones are desirable, which ones are absolutely necessary, which ones should have priority and they will have to believe in them enough to say yes, we will raise the taxes to pay for them.

I just wanted you to know that you are speaking to a receptive audience this morning.

In reference to medicare and medicaid, I am not critical of anybody else, but it just so happens that I did not vote to originate either one of them. At the same time, I feel that the care of those citizens who are unable to get reasonable and adequate medical care from any other source is the responsibility of the Government.

I, however, would like to see that responsibility exercised on the local level and not from Washington. I think that that avoids many problems. It avoids the problems of regulations and control of businesses, operations in the private sector, as well as professional.

My idea of revenue sharing is that you first balance the Federal budget, then you release areas of taxation so that the State can pick it up.

I am convinced that the American people are very thoughtful, intelligent, generous, and good, and on the local level, the handling of many aspects of welfare, including medical care for those who cannot provide it any other way, would result in not only a better program, but I think there would be more compassionate and helpful care to the individuals who must receive medical care at public expense.

Would you concur with that general statement with reference to local control?

Dr. DORRITY. Absolutely. In fact, I think the first responsibility lies with the families. Then, I think if they cannot handle it, the churches; if they cannot handle it, the community; if they cannot handle it, the cities and counties; if they cannot handle it, then the States. But never as far as the Federal level. I go along with that.

I have a couple of other suggestions. I am pleased to hear your comments about the fiscal responsibility. This has bothered me for a long time and I think that our way out of the mess that we are in is if we return to fiscal responsibility, fiscal sanity, with sound money systems, no compromise for 5 to 10 percent inflation per year.

You cannot lose 5 percent of anything 20 times, or it is gone.

At the present time, if we return to sound money, fiscal responsibility, constitutional government and the Ten Commandments, we can ride out the storm. If we cannot, we will hit the bottom.

Senator CURTIS. I have no further questions.

You alluded to section 1801 of the act. I would like to have that printed in the record at this point.

Senator TALMADGE. Without objection, it will be.

[The material referred to follows:]

PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

Section 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Senator TALMADGE. Thank you very much, Dr. Dorrity, for your contribution.

The next witness is Dr. Dave M. Davis, immediate past president, Georgia Psychiatric Association and director, psychiatric services, Peachtree-Parkwood Mental Health Center, on behalf of the Amer-

American Psychiatric Association and National Association of Private Psychiatric Hospitals.

Dr. Davis, it is a pleasure to welcome you before our committee as a valued friend and a valued constituent.

STATEMENT OF DAVE M. DAVIS, M.D., IMMEDIATE PAST PRESIDENT, GEORGIA PSYCHIATRIC ASSOCIATION, DIRECTOR OF PSYCHIATRIC SERVICES, PEACHTREE-PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS, ATLANTA, GA., ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Dr. DAVIS. Thank you.

With me is Mr. Caesar A. Giolito, American Psychiatric Association. I am here to present the views of the American Psychiatric Association, which represents 23,000 psychiatrists in the United States, and of the National Association of Private Psychiatric Hospitals, which represents 178 free-standing psychiatric facilities, containing over 15,000 beds.

We share the concern of the author and cosponsors of S. 1470 regarding the need to contain rising health care costs and support the objectives of this bill to achieve this goal.

While we believe and urge that equal attention be paid to the needs of Americans with mental and emotional illness vis-a-vis those with physical illness, we understand that the purpose of the bill is a long-term basic structural solution to the vexing problem of rising health care costs.

To achieve that important goal, we recommend your consideration of amending the bill to authorize a demonstration program—subject to rigorous, ongoing, organized peer review—to determine—as we believe it will—that appropriate psychiatric intervention and treatment does reduce medical care costs.

We would be pleased to work with the committee professional staff and develop the appropriate amendment to achieve that goal, if the committee is interested in pursuing that objective.

Senator TALMADGE. If you would excuse me, there is a record vote on the Senate floor. I will go over and cast my ballot and return immediately.

The committee will stand in recess momentarily, subject to the call of the Chair.

[A brief recess was taken.]

Senator TALMADGE. The subcommittee will be in order.

Dr. Davis, my apologies for having to recess for the vote. You may proceed where you left off.

Dr. DAVIS. Senator, we recommend your consideration of amending the bill to authorize the demonstration project, subject to rigorous, ongoing, organized review, to determine, as we believe it will, that appropriate psychiatric intervention and treatment does reduce medical care costs.

We believe that such a demonstration program would prove that the placing of psychiatric benefits in medicare on a par with physical illness benefits would result in even greater cost savings. It has been dem-

onstrated that 50 percent or more of persons who present themselves to physicians with physical complaints suffer from some component of mental or emotional illness.

Experience shows us that the elderly are especially prone to psychosomatic complaints. If provided with necessary psychiatric treatment, this population group would be lower utilizers of expensive testing and medical services.

We believe that such a demonstration project would prove that the provision of psychiatric treatment to medicaid recipients—age 22 to 64—in psychiatric hospitals will effect cost savings. This age group—22 to 64—is currently covered for psychiatric care only in State mental or general hospitals.

The American Psychiatric Association testified before the House on the Medicare-Medicaid Antifraud and Abuse Amendments, H.R. 3, on March 7, 1977. We stated that fraud and abuse would be minimized through the implementation of improved administrative policies and practices.

We need to encourage competent physicians to participate in medicare and medicaid. If we discourage competent physicians from participation through excessive administrative constraints, unrealistic reimbursement, and restrictive patient benefits, we will perpetuate the prevalence of providers who deliver poor quality care and who may be abusive and fraudulent.

The medicare and medicaid benefits and reimbursement policies for the coverage of mental illness, as presently constituted, can only discourage qualified professional participation and deprive the patient of cost-effective services.

For example, psychiatrists who participate in the medicaid program in Georgia receive from \$28 to \$32 per hour, while in community mental health centers the medicaid program is billed in Georgia at the rate of \$22 for each 15 minute segment, or at the hourly aggregate of \$88 for a patient who receives service in the center, regardless of the credentials or professional qualifications of the person providing the service.

Senator TALMADGE. Do you mean the payments they make under medicaid in Georgia is not limited to a specific psychiatrist? Who else do they pay?

Dr. DAVIS. Directly to the community mental health center. I was given the latest payment schedule, \$22 per 15 minutes, regardless of who delivers that service.

Senator TALMADGE. That is poetry, dance therapists, things of that nature?

Dr. DAVIS. Whoever that community mental health center designated to see that particular individual.

Senator TALMADGE. That is authorized by State law?

Dr. DAVIS. I do not know if that is the law. I know that is how they pay it out presently.

Senator TALMADGE. I appreciate your bringing that up and looking into it with the committee staff. If that is going on, it should be corrected.

Dr. DAVIS. I agree very much. I will send you a copy of the schedule that I recently got from the Department.

Senator TALMADGE. Please do.

[At presstime the information was not received. The committee was informed that the information will be forthcoming.]

Dr. DAVIS. The classification of hospitals into separate categories is a reasonable approach. However, we feel that involved groups and associations should have the opportunity to be a part of the process which determines classification together with the Secretary of DHEW. There are numerous factors that should be considered, such as whether the facility is a teaching hospital, the intensity of the teaching facilities, and whether the hospital provides community services.

Variables such as patterns of personnel requirements in these institutions will differ markedly. There also exists a vagueness in the bill in relation to the grouping of psychiatric hospitals with geriatric, maternity or other specialty hospitals. S. 1470 states that whether or not they are to be grouped together or separately is to be determined by the Secretary of HEW.

These associations support the prospective reimbursement of hospitals, which is already being utilized successfully in a number of States and recommend continued experimentation in this area as authorized under Public Law 92-603. We also support incentive reimbursement based on routine operating costs, making exceptions for capital and related costs, energy costs, malpractice insurance expense, and so forth.

Although supportive of this approach, we wish to caution the committee that there may be a danger that hospital administrators may move to the extremes in the incentives of 120-percent overcost reimbursement or the 5-percent rebate, since there appears little to be gained by being in the middle.

In this exemption procedure for determining reasonable costs in cases where the hospital is located in an underserved area; certified as being currently necessary by an appropriate planning agency; and underutilized, we strongly recommend that an additional exception be made for psychiatric hospitals with underutilized beds.

Patterns of underutilized beds in psychiatric hospitals have been established because of the lack of third-party payment mechanisms to defray the costs, and do not reflect patient needs in any particular area. However, a recent trend in state legislation mandating the coverage of inpatient and outpatient psychiatric treatment in health insurance policies is beginning to fill these beds. In the meantime, we must encourage meeting patient needs by exempting psychiatric hospitals that have had artificial barriers imposed for the inpatient treatment of mental illness.

Encouraging physicians to accept assignment through the \$1 per patient administrative cost incentive has been employed by Blue Cross-Blue Shield, and could be an effective incentive in some cases. However, it does not address the problem in the treatment of psychiatric outpatients where the benefits are so limited as to discourage physician participation altogether. For the outpatient treatment of psychiatric illness it only represents a token gesture and we are concerned that will not have any impact.

We wish to commend the chairman and this committee on section 11 (f) which encourages physician participation in shortage areas. We continue to hold the position that in medicare, the mechanism to determine reasonable charges for physician services should be structured in such a way as to provide usual customary and reasonable payment.

We understand that the payment mechanism in S. 1470 is even more restrictive than it was in S. 3205 inasmuch as no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level after the economic index is applied. We are concerned that such a measure will not encourage physician acceptance of assignment.

Relative value schedules have been the subject of much debate in psychiatry. If these schedules are to be developed, the specialty of psychiatry must have ample opportunity for input into the process, and experiments should be held around the country to assess their usefulness.

In reference to visits away from institution by patients of skilled nursing or intermediate care facilities, that is analagous to therapeutic leave which is used in many psychiatric facilities and held to be an important and efficacious tool in the treatment of the mentally and emotionally ill. Therapeutic leave can be an excellent indicator of the progress that a mental patient is making, and can provide valuable information for the further effective treatment of the patient, that cannot be developed in any other way.

It also enables the patient who has progressed beyond a certain point in treatment to establish his initial capabilities to reintegrate into the community, but not precipitously.

Programs such as CHAMPUS do provide for hospital therapeutic leave for psychiatric illness, and we believe that this committee should consider psychiatric therapeutic leave in the medicare program.

The outpatient psychiatric benefit in medicare of \$250, or 50 percent of cost, which ever is less, is both unrealistic because of the demonstrably low utilization of psychiatric care in medicare, and because it causes mentally ill patients, who could be treated in the community, to be hospitalized. In the absence of outpatient benefits, mental conditions can become exacerbated and require hospitalization, or physicians wishing to treat patients without outpatient psychiatric benefits may have no other alternative but to hospitalize them.

Moreover, the 190-day lifetime limitation in psychiatric hospitals under medicare, results in mentally ill patients being treated in more costly general hospital settings. The average per diem rate in psychiatric hospitals runs between \$58 to \$174, as compared with \$250 and \$350 for medical/surgical hospitals.

In the latest year for which data are available, medicare expenditures for hospital care for mental conditions amounted to \$4.40 per person covered—\$3.30 in general hospitals and \$1.10 in psychiatric hospitals. There is no indication that more recent data will show these figures have risen other than proportionately to the rise in the elderly population since that time.

Both the American Psychiatric Association and the National Association of Private Psychiatric Hospitals stand ready to give this committee every possible assistance in the full consideration of the matters that have been raised in our testimony.

Senator TALMADGE. Thank you very much, Doctor.

Is the thrust of your argument that the Government could have money by permitting more outpatient psychiatric care rather than hospitalize them?

Dr. DAVIS. Yes. I know the medicaid and medicare reimbursement schedule, there is some pressure, almost, to treat a patient in a way that might be more expensive, since there is such a limited benefit available for outpatient. It might force the physician to hospitalize the person, where he possibly could be treated in a day patient or outpatient setting.

Senator TALMADGE. Would you submit data to the committee staff to support your argument that we can actually save money? The reluctance of the Committee on Finance and the Ways and Means Committee to expand the coverage for psychiatric care, has been in large part based on cost and no one to date has been able to submit any evidence to what the cost might be, \$100 million, \$5 million—so if you can submit some reasonable argument that it would save money by including some of what you have recommended, we would certainly like to have evidence of that.

Thus far, no one who has ever appeared before one of our committees has had the slightest idea of what it would cost if we would write a check that said “unlimited psychiatric treatment.”

Dr. DAVIS. I understand your concern.

This is the reason we are recommending the amendment to include a demonstration project which would be funded by the Federal Government, and I think it would have a great deal of credibility. These other studies are pretty good and pretty indicative. I will send them along to you.

Senator TALMADGE. Thank you.

Senator Dole?

Senator DOLE. I am just curious about the number of psychiatric patients who are hospitalized in general hospitals as opposed to psychiatric hospitals.

Dr. DAVIS. You are asking about the number?

Senator DOLE. Yes. If you do not have it, furnish it for the record.

[The figures requested by Senator Dole and information previously requested by Senator Talmadge follow. Oral testimony continues on p. 432.]

There are 28,706 psychiatric beds in non-Federal general hospitals, and 16,091 beds in private psychiatric hospitals, out of a grand total of 332,127 psychiatric beds in all types of facilities in the United States. The preponderant number of psychiatric beds (222,202) are in State and county mental hospitals. Other settings include VA hospitals, CMHC's, residential treatment centers, etc.

The utilization of beds in all of these settings ranges from approximately 63 percent to 89 percent.

Source: Hospitals Statistics, 1976 edition, American Hospital Association; from the 1975 annual survey.

BENEFITS OF MENTAL HEALTH CARE FOR HEALTH SERVICE UTILIZATION

I would like to bring to your attention four studies which directly address the issue of benefits of mental health care. These studies show substantial savings in the cost of non-mental health care within Health Maintenance Organizations and health insurance plans that provide mental health benefits.

The first study took place in Group Health Association of Washington.¹ This

¹Goldberg, Irving D. et al. “Effect of a Short-Term Outpatient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program.” *Medical Care* 8: 419-428 (September-October 1970).

Clerk's Note.—Reprinted in this hearing at page 423.

study indicated that patients treated by mental health providers reduced their non-psychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the preceding year. Use of laboratory and x-ray services declined by 29.8 percent. These cost savings were compared to the direct costs of providing care and it turns out that GHA has actually saved money by providing mental health services.

The second study took place in a Kaiser Plan in California.² This study took a look, over a long time period, at the utilization experience of a group of mental health users and a comparison group. The conclusion of this study was that the net cost of psychiatric care in the year of therapy was \$22 or about two cents per enrollee per month (approximately 1 percent utilization). The return on this cost is a savings in subsequent years of \$200 to \$250 per case or about 20 cents per enrollee per month.

Third study: The West German Psychoanalytic Studies. A number of studies^{3,4} took place about 20 years ago in the Federal Republic of Germany which are of great significance today in U.S.A. discussions of psychiatric coverage under National Health Insurance. The most significant studies were done by Annemarie Duehrssen, M.D. and colleagues of the Central Institute of Psychogenic Illness of the Berlin General Health Insurance office. She and her colleagues did a most extensive followup of patients after analytic psychotherapy or psychoanalysis by developing an evaluation system at the onset and the end of treatment and then followed up on nearly a thousand patients after five years.

The criteria used for evaluating patients in this particular study included (1) a precise description of the symptoms of illness as well as duration; (2) utilization of health care especially in-hospital care; (3) the work capacity of the individuals; and (4) self-evaluation by the patients themselves of their own treatment.

Of the 1,000 4 study patients who underwent individual analytic psychotherapy or psychoanalysis the average number of hours of treatment were 100, 13 percent ended treatment prematurely, 12 percent continued privately after their limits of 200 treatments ran out and 10 percent desired further treatment after 200 visits but could not afford further treatment. One hundred one of the study patients could not be found at five-year followup, 13 had died and of the ensuing 890 reachable patients 845 were evaluated, certainly an extremely high response rate. Only 45 refused followup. Six hundred forty-seven were followed up in five years by direct interviews, 104 returned detailed questionnaires and 94 had home visits by a social worker.

In terms of outcome 13 percent of the patients were felt to have had at least one relapse during the five-year followup period. The most interesting statistic was that of the 845 followed up patients the hospital rate was .78 hospital days per year which compared to the pretreatment average of 5.3 days per year and a general average for the insured population of 2.5 hospital days per year. This is hospital days for any illness not just mental illness. Prognostic measures, built in at the onset of treatment, also had a high degree of validity and reliability: that is those with favorable prognosis had excellent outcome measures at the termination of treatment which held true a five-year follow-up. Those with unfavorable prognosis may have had an excellent or good evaluation after termination of treatment but that seemed to disappear at five-year followup. Therefore, the prognosis variables seem much more reliable at five-year followup than at termination.

The explanation for this was that it was much more observer biased at the termination of evaluation. The observer problem, I think, was inadequately addressed in these studies. It looked like there were at least three examiners, an initial examiner who determined the prognosis, a treater who did the followup at termination and a third and different five-year followup doctor. There was also a very high degree of patient satisfaction, 81 percent feeling strongly at five-year followup that they had been helped by the treatment.

Although there may be some methodological problems with this particular study, it is clear that followups had been conducted on a large number of patients with a sufficiently long interval between treatment and followup and

² Follette, William and Cummings, Nicholas A. "Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting." *Medical Care* 5: 25-35 (January-February 1967.)

Reprinted in this hearing at page 415.

³ Duehrssen, Annemarie: Katamnestiche Ergebnisse bei 1004 Patienten nach analytischer Psychotherapie. *Zschr. Psycho-som. Med* VIII, 2/62. Verlag Fuer Medizinische Psychologie (Goettingen).

⁴ Duehrssen, Anne marie : Die Beurteilung des Behandlungserfolges in der Psychotherapie. *Zschr. Psycho-som. Med* III, 3/57. Verlag Fuer Medizinische Psychologie (Gottigen).

it was this kind of research which helped both preserve and extend the National Health Insurance benefit for the mentally ill in West Germany and led to a more efficient and effective prior authorization and peer review system throughout that country.

The fourth study⁵ is a more recent study by the Research Department of Blue Cross and Western Pennsylvania which assessed the medical/surgical utilization of a group of subscribers (N:169) who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers. The findings showed that medical/surgical utilization was reduced significantly for the group who used the psychiatric benefit. The monthly cost per patient for medical services dropped by \$9.41, from \$16.47 to \$7.06. This was well below the average per capita cost for the control group. Both medical/surgical inpatient days per month and outpatient visits per month were down by more than 54 percent. Further, this phenomenon or reduced medical/surgical utilization with exposure to outpatient psychotherapy was found to be independent of age, sex, or employment level.

The above four studies suggest that significant benefits accrue to an insurance or prepaid system when mental health benefits are available and accessible. Any discussion about coverage for mental health under national health insurance must take these findings into account.

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PSYCHIATRIC SERVICES AND MEDICAL UTILIZATION IN A PREPAID HEALTH PLAN SETTING

(By William Follette, M.D.,* and Nicholas A. Cumming, Ph.D.**)

In two previous studies [5, 6] the psychiatric practitioner's contention that emotionally disturbed patients do not seek organic treatment for their complaints following the intervention of psychotherapy have been investigated. Although it has long been recognized that a large number of the physical complaints seen by the physician are emotionally, rather than organically, determined, the more precise relationship between problems in living and their possible expression through apparent physical symptomatology has been difficult to test experimentally. As noted in the previous study, the GHI Project [1] demonstrated that users of psychiatric services were also significantly frequent users of medical services, but the Project was not able to answer the question of whether there is a reduction in the use of medical services following psychotherapy.

Because the facilities and structure of the Kaiser Foundation Health Plan accord an experimental milieu not available to Avnet, the original pilot project in San Francisco was able to demonstrate a significant reduction in medical utilization between the year prior to psychotherapy, and the two years following its intervention. Certain methodologic problems inherent to the pilot study indicated caution and the need for refinement and replication to avoid arriving at premature conclusions. The lack of a control group of what might be termed psychologically-disturbed high-utilizers who did not receive psychotherapy was a serious omission in the first experiment. † Furthermore, an error in the tabulation of in-

⁵Jameson, John, Shuman, Larry J., and Young, Wanda W. "The effects of Outpatient Psychiatric Utilization on the Costs of Providing Third-Party Coverage. Res. Series 18. December, 1976.

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This paper is a report of the first of two investigations seeking to develop and test methods of assessing the effect of psychiatric services on medical utilization in a comprehensive medical program. Part II deals with prospective, rather than retrospective, methodology, and will be reported later.

† The authors acknowledge their debt to Dr. M. F. Collen for this and other suggestions, and to Mr. Arthur Weissman, Medical Economist, Kaiser Foundation Medical care entities, for his expert consultation.

patient utilization was discovered after the experiment had been concluded. †† In addition, the question was raised whether the patients studied might, subsequent to the two years following psychotherapy, revert to previous patterns of somatization or, as a new pattern, merely substitute protracted and costly psychotherapy for previous medical treatment.

THE PROBLEM

This study investigated the question of whether there is a change in patients' utilization of outpatient and inpatient medical facilities after psychotherapy, comparing the patients studied to a matched group who did not receive psychotherapy.

Psychotherapy was defined as any contact with the Department of Psychiatry, even if the patient was seen for an initial interview only. The year prior to the initial contact was compared with the five subsequent years in both groups.

The problem can be stated simply: Is the provision of psychiatric services associated with a reduction of medical services utilization (defined as visits to other medical clinics, outpatient laboratory and x-ray procedures, and days of hospitalization)?

METHODOLOGY

The setting.—The Kaiser Foundation Health Plan in the Northern California Region is a group-practice prepayment plan offering comprehensive hospital and professional services on a direct service basis. Professional services are provided by the Permanente Medical Group—a partnership of physicians. The Medical Group has a contract to provide comprehensive medical care to the subscribers, of whom there were more than a half million at the time of this study. The composition of the Health Plan subscribers is diverse, encompassing most socioeconomic groups. The Permanente Medical Group comprises all major medical specialties; referral from one specialty clinic to another is facilitated by the organizational features of group practice, geographical proximity and use of common medical records. During the years of this study (1950–1964), psychiatry was essentially not covered by the Northern California Health Plan on a prepaid basis, but in some areas of the Northern California region psychiatric services were available to Health Plan Subscribers at reduced rates. During the six years of the study, the psychiatric clinic staff in San Francisco consisted of psychiatrists, clinical psychologists, psychiatric social workers, resident psychiatrists at the third- or fourth-year level, and psychology interns, all full-time. The clinic operates primarily as an out-patient service for adults (age eighteen or older), for the evaluation and treatment of emotional disorders, but it also provides consultation for non-psychiatric physicians and consultation in the general hospital and the emergency room. There is no formal "intake" procedure, the first visit with any staff member being considered potentially therapeutic as well as evaluative and dispositional. Regardless of professional discipline, the person who sees the patient initially becomes that patient's therapist unless there is a reason for transfer to some other staff member, and he continues to see the patient for the duration of the therapy. An attempt is made to schedule the first interview as soon as possible after the patient calls for an appointment. There is also a "drop-in" or non-appointment service for emergencies so that patients in urgent need of psychiatric help usually can be seen immediately or at least within an hour or two of arrival at the clinic.

One of the unique aspects of this kind of associated health plan and medical group is that it tends to put a premium on health rather than on illness, i.e., it makes preventive medicine economically rewarding, thereby stimulating a constant search for the most effective and specific methods of treatment. The question of how psychiatry fits into comprehensive prepaid medical care is largely unexplored; there are not many settings in which it can be answered. Another feature of group practice in this setting is that all medical records for each patient are retained within the organization.

Subjects.—The experimental subjects for this investigation were selected systematically by including every fifth psychiatric patient whose initial interview took place between January 1 and December 31, 1960. Of the 152 patients thus selected, 80 were seen for one interview only, 41 were seen for two to eight

†† At that time days of hospitalization per patient and by year were tabulated from each patient's outpatient medical records. Subsequent investigation has revealed that only about a third of the outpatient charts reviewed contained summaries of hospital admissions, and that tabulation of inpatient utilization must be made directly through the separately-kept inpatient records.

interviews (mean of 6.2) and were defined as "brief therapy," and 31 were seen for nine or more interviews (mean of 33.9) and were defined as "long-term therapy."

Thus, each experimental patient was matched with a control patient in the criteria above, but without reference to any other variable. Both samples ranged in age from 24 to 62, with a mean of 38.1. Of these, 52 percent were women and 63 percent were blue-collar workers or their dependents. The satisfaction of so many criteria in choosing a matched control group proved to be a tedious and time-consuming procedure.

Review of the medical records of the psychiatric sample disclosed consistent and conceptually useful notations in the year prior to the patients' coming to psychotherapy, which could be considered as criteria of psychological distress. These consisted of recordings, made by the physicians on the dates of the patients' visits, which were indicative of those patients' emotional distress, whether or not the physicians recognized this when they made the notations. These (38) criteria were assigned weights from one to three in accordance with the frequency of their appearance in medical records and in accordance with clinical experience about the significance of the criteria when encountered in psychotherapeutic practice. The criteria, with weights assigned, are presented in Table 1. In comparing the charts of the psychiatric patients with those of Health Plan patients randomly drawn, it was determined that although some criteria were occasionally present in the medical records of the latter, a weighted score of three within one year clearly differentiated the psychiatric from the non-psychiatric groups. Accordingly, therefore, in matching the control (non-psychotherapy) group to the experimental (psychotherapy) group, the patients selected had records which indicated scores of three or more points for the year 1959. The mean weights of the three experimental groups and the control group in terms of the 38 criteria of psychological distress are presented in Table 2: note that there was no significant difference between this dimension of the two groups in 1959.

TABLE 1—CRITERIA OF PSYCHOLOGICAL DISTRESS WITH ASSIGNED WEIGHTS

1 point	2 points	3 points
1. Tranquilizer or sedative requested.	23. Fear of cancer, brain tumor, venereal disease, heart disease, leukemia, diabetes, etc.	34. Unsubstantiated complaint there is something wrong with genitals.
2. Doctor's statement patient is tense, chronically tired, was reassured, etc.	24. Health Questionnaire: yes on 3 or more psychological questions. ¹	35. Psychiatric referral made or requested.
3. Patient's statement as in No. 2.	25. 2 or more accidents (bona fractures, etc.) within 1 yr. Patient may be alcoholic.	36. Suicidal attempt, threat, or preoccupation.
4. Lumps in throat.	26. Alcoholism or its complications: delirium tremens, peripheral neuropathy, cirrhosis.	37. Fear of homosexuals or of homosexuality.
5. Health questionnaire: yes on 1 or 2 psychological questions.	27. Spouse is angry at doctor and demands different treatment or patient.	38. Nonorganic delusions and/or hallucinations; paranoid ideation; psychotic thinking or psychotic behavior.
6. Alopecia areata.	28. Seen by hypnotist or seeks referral to hypnotist.	
7. Vague, unsubstantiated pain.	29. Requests surgery, which is refused.	
8. Tranquilizer or sedative given.	30. Vasectomy: requested or performed.	
9. Vitamin B ₁₂ shots (except for pernicious anemia).	31. Hyperventilation syndrome.	
10. Negative EEG.	32. Repetitive movements noted by doctor: tics, grimaces, manneisms, torticollis, hysterical seizures.	
11. Migraine or psychogenic headache.	33. Weight-lifting and/or health fadism.	
12. More than 4 upper respiratory infections per year.		
13. Menstrual or premenstrual tension; menopausal sx.		
14. Consults doctor about difficulty in child rearing.		
15. Chronic allergic state.		
16. Compulsive eating (or overeating).		
17. Chronic gastrointestinal upset; aerophagia.		
18. Chronic skin disease.		
19. Anal pruritus.		
20. Excessive scratching.		
21. Use of emergency room: 2 or more per year.		
22. Brings written list of symptoms or complaints to doctor.		

¹ Refers to the last 4 questions (relating to emotional distress) on a Modified Cornell Medical Index—a general medical questionnaire given to patients undergoing the multiphasic health check in the years concerned (1959-62).

TABLE 2.—SCORES FOR CRITERIA OF PSYCHOLOGICAL DISTRESS, FOR THE EXPERIMENTAL GROUPS AND THE CONTROL GROUP DURING THE YEAR PRIOR TO PSYCHOTHERAPY (1959)

Group	Total score	Number of patients	Average score
1 session only.....	264	80	3.30
Brief therapy.....	134	41	3.27
Long-term therapy.....	246	31	7.94
All experimental (psychotherapy) groups.....	644	152	4.24
Control (nonpsychotherapy) group.....	629	152	4.13

In order to facilitate comparison of the experimental (psychotherapy) and control (non-psychotherapy) groups, one last criterion for inclusion in the matched group was employed. Each subject in the control group had to be a Health Plan member for the first three consecutive years under investigation inasmuch as the experimental group, though demonstrating attrition in continued membership after that time, remained intact for those years.

Dependent variable.—Each psychiatric patient's utilization of health facilities was investigated first for the full year preceding the day of his initial interview, then for each of the succeeding five years beginning with the day after his initial interview.

The corresponding years were investigated for the control group which, of course, was not seen in the Department of Psychiatry. This investigation consisted of a straightforward tabulation of each contact with any outpatient facility, each laboratory report and x-ray report. In addition a tabulation of number of days of hospitalization was made without regard to the type or quantity of service provided. Each patient's utilization scores consisted of the total number of separate outpatient and inpatient tabulations.

RESULTS

The results of this study are summarized in Table 3, which shows the differences by group in utilization of outpatient medical facilities in the year before and the five years after the initial interview for the psychiatric sample, and the utilization of outpatient medical services for the corresponding six years for the non-psychotherapy sample.

TABLE 3.—UTILIZATION OF OUTPATIENT MEDICAL SERVICES (EXCLUDING PSYCHIATRY) BY PSYCHOTHERAPY GROUPS FOR THE YEAR BEFORE (1-B) AND THE 5 YR AFTER (1-A, 2-A, 3-A, 4-A, 5-A) THE INITIAL INTERVIEW, AND THE CORRESPONDING YEARS FOR THE NONPSYCHIATRIC GROUP

Group	1-B	1-A	2-A	3-A	4-A	5-A
1 session only, unit score.....	911	815	612	372	321	217
Number of patients.....	80	80	80	57	53	49
Average.....	11.4	10.2	7.7	6.5	6.1	4.4
Brief therapy, unit score.....	778	471	354	202	215	155
Number of patients.....	41	41	41	32	30	27
Average.....	19.0	11.5	8.6	6.3	7.2	5.7
Long-term therapy, unit score.....	359	323	279	236	151	108
Number of patients.....	31	31	31	27	24	19
Average.....	11.6	10.4	9.0	8.7	6.5	5.7
All experimental (psychotherapy) groups, unit score.....	2,048	1,609	1,245	810	687	480
Number of patients.....	152	152	152	116	107	95
Average.....	13.5	10.6	8.2	6.4	6.4	5.1
Control (nonpsychotherapy) group, unit score.....	1,726	1,743	1,718	1,577	1,611	1,264
Number of patients.....	152	152	152	127	111	98
Average.....	11.4	11.5	11.3	12.4	14.5	12.9

The data of Table 3 are summarized as percentage in Table 4, which indicates a decline in outpatient medical (not including psychiatric) utilization for all three psychotherapy groups for the years following the initial interview, while there is a tendency for the non-psychotherapy patients to increase medical utilization during the corresponding years. Applying t-tests of the significance of the standard error of the difference between the means of the "year before" and the means of each of the five "years after" (as compared to the year before), the following results obtain. The declines in outpatient (non-psychiatric) utilization for the "one session only" and the "long-term therapy" groups are not significant

for the first year following the initial interview while the declines are significant at either the .05 or .01 levels for the remaining four years. In the "brief therapy" group, there are statistically significant declines in all five of the years following the initial interview. As further indicated in Table 4, there is a tendency for the control group to *increase* its utilization of medical services, but this proved significant for the "fourth year after" only.

TABLE 4.—COMPARISON OF THE YEAR PRIOR TO THE INITIAL INTERVIEW WITH EACH SUCCEEDING YEAR, INDICATING PERCENT DECLINE OR PERCENT INCREASE (LATTER SHOWN IN PARENTHESES) IN OUTPATIENT MEDICAL (NONPSYCHIATRIC) UTILIZATION BY PSYCHOTHERAPY GROUPING, AND CORRESPONDING COMPARISONS FOR THE CONTROL GROUP, WITH LEVELS OF SIGNIFICANCE

Group	1-A		2-A		3-A		4-A		5-A	
	Per- cent change	Signifi- cance	Per- cent change	Signifi- cance	Per- cent change	Signifi- cance	Per- cent change	Signifi- cance	Per- cent change	Signifi- cance
1 session only.....	10.5	(¹)	32.8	0.05	44.75	0.05	46.5	0.05	61.4	0.01
Brief therapy.....	39.5	0.05	53.2	.05	66.8	.01	62.1	.01	70.0	.01
Long-term therapy.....	10.0	(¹)	22.3	.05	25.0	.05	43.0	.05	50.9	.05
All experimental (psycho- therapy) groups.....	21.4	.05	39.2	.01	48.2	.01	52.3	.01	62.5	.01
Control (nonpsychotherapy) group.....	(²)	-----	(²)	-----	(8.8)	(¹)	(27.2)	.05	(13.2)	(¹)

¹ No significance

² None

The question was raised as to whether the patients demonstrating declines in medical utilization have done so because they have merely substituted protracted psychotherapy visits for their previous medical visits.

As shown in Table 5, the number of patients in the one-session-only group who return in the third to fifth years for additional visits is negligible. Comparable results are seen in the brief-therapy group. In contrast, the long-term-therapy group reduces its psychiatric utilization by more than half in the "second year after," but maintains this level in the succeeding three years. By adding the outpatient medical visits to the psychiatric visits, it becomes clear that whereas the first two psychotherapy groups have not substituted psychotherapy for medical visits, this does seem to be the case in the long-term psychotherapy group. These results are shown in Table 6, and indicate that the *combined* outpatient utilization remains about the same from the "year before" to the "fifth year after" for the third psychotherapy group, while declines are evident for the first two psychotherapy groups. As regards the combined (medical plus psychiatric) utilization, the long-term psychotherapy group is not appreciably different from the control (non-psychiatric) group.

TABLE 5.—AVERAGE NUMBER OF PSYCHOTHERAPY SESSIONS PER YEAR FOR 5 YEARS BY EXPERIMENTAL GROUP

Group	1-A	2-A	3-A	4-A	5-A
1 session only.....	1.00	0	0	0.02	0.06
Brief therapy.....	6.22	0	.09	.57	.52
Long-term therapy.....	12.33	5.08	5.56	5.88	5.05

TABLE 6.—COMBINED AVERAGES (OUTPATIENT MEDICAL PLUS PSYCHOTHERAPY VISITS) OF UTILIZATION BY YEARS BEFORE AND AFTER PSYCHOTHERAPY FOR THE EXPERIMENTAL GROUPS, AND TOTAL OUTPATIENT UTILIZATION BY CORRESPONDING YEARS FOR THE CONTROL (NONPSYCHIATRIC) GROUP

Group	1-B	1-A	2-A	3-A	4-A	5-A
1 session only.....	11.4	11.2	7.7	6.5	6.1	4.5
Brief therapy.....	19.0	17.7	8.6	6.4	7.7	6.2
Long-term therapy.....	11.6	22.7	14.1	14.3	12.4	10.8
All experimental (psychotherapy) groups.....	13.5	15.3	9.2	8.3	7.9	6.2
Control group.....	11.4	11.5	11.3	12.4	14.5	12.9

Investigation of inpatient utilization reveals a steady decline in utilization in the three psychotherapy groups from the "year before" to the "second year after," with the three remaining "years after" maintaining the level of utilization attained in the "second year after." In contrast, the control sample demonstrated a constant level in number of hospital days throughout the six years studied. These results are shown in Table 7, which indicates that the approximately 60 per cent decline in number of days of hospitalization between the "year before" and the "second year after" for the first two psychotherapy groups is maintained to the "fifth year after"; this decline is significant at the .01 level. The inpatient utilization for the "long-term therapy" group in the "year before" was over twice that of the nonpsychiatric sample, and about three times that of the first two psychotherapy groups. The significant (.01 level) decline of 88 per cent from the "year before" to the "second year after" is maintained through the "fifth year after," rendering the inpatient utilization of the third psychotherapy group comparable to that of the first two psychotherapy groups.

TABLE 7.—NUMBER OF DAYS OF HOSPITALIZATION AND AVERAGES BY PSYCHOTHERAPY GROUP FOR THE YEAR BEFORE AND THE 5 YR AFTER PSYCHOTHERAPY, AND THE CORRESPONDING PERIOD FOR THE NONPSYCHOTHERAPY GROUP

Group	1-B	1-A	2-A	3-A	4-A	5-A
One session only, pays per year.....	117	78	52	32	33	31
Number of patients.....	80	80	80	57	53	49
Average.....	1.46	.98	.65	.56	.62	.63
Brief therapy, days per year.....	66	44	31	24	23	23
Number of patients.....	41	41	41	32	30	27
Average.....	1.61	1.07	.76	.75	.77	.85
Long-term therapy, days per year.....	153	37	19	18	16	13
Number of patients.....	31	31	31	27	24	19
Average.....	4.94	1.09	.61	.67	.67	.68
All experimental (psychotherapy) groups, days per year.....	336	159	102	74	72	67
Number of patients.....	152	152	152	116	107	95
Average.....	2.21	1.05	.68	.64	.67	.71
Significance.....		.05	.02	.05	.05	.05
Control (nonpsychotherapy) group, days per year.....	324	307	477	255	208	197
Number of patients.....	152	152	152	127	111	98
Average.....	2.13	2.02	3.07	2.02	1.87	2.01
Significance.....		(1)	.05	(1)	(1)	(1)

¹ None.

Note.—Health Plan average is 0.8 per year for patients 20 yr old or older.

In terms of decline in use of inpatient services (days of hospitalization), however, the long-term psychotherapy group and the control group are different, in that the former patients significantly reduce their inpatient utilization from the "year before" to the "fifth year after." However, the small size of the samples limits the conclusions that can be drawn.

DISCUSSION

The original pilot study of which this project is an outgrowth was proposed by the senior author as an aid in planning for psychiatric care as part of comprehensive prepaid health-plan coverage. It had long been observed that some of this psychiatric clinic's patients, as well as many patients in the hospital for whom a psychiatric consultation was requested, had very thick medical charts. It was also repeatedly noted that when these patients were treated from a psychiatric point of reference, i.e., as a person who might have primarily emotional distress which was expressed in physical symptoms, they often abandoned their physical complaints. It seemed reasonable to expect that for many of these people, psychiatrically-oriented help was a more specific and relevant kind of treatment than the usual medical treatments.

This would be especially true if the effects of psychiatric help were relatively long-lasting, or if a change in the patient affected others in his immediate environment. In the long run, the interruption of the transmission of sick ways of living to succeeding generations would be the most fundamental and efficient kind of preventive medicine. It therefore seemed imperative to test the intuitive impressions that this kind of patient could be treated more effectively by an unstructured psychiatric interview technique than by the more traditional medical routine with its directed history.

The Balints [2, 3] have published many valuable case reports which describe the change in quantity and quality in patients' appeals to the general practitioner after the latter learns to listen and understand his patients as people in distress because of current and past life experiences. It would be difficult, however, to design a statistical study of those patients and of a matched control group treated for similar complaints in a more conventional manner.

Psychiatry has been in an ambivalent position in relation to the rest of medicine: welcomed by some, resented by others, often, however, with considerable politeness which serves to cover up deep-seated fears of and prejudices against "something different." In a medical group associated with a prepaid health plan, conditions are favorable for integrating psychiatry into the medical fraternity as a welcomed and amiliar (therefore unthreatening) member specialty. The inherent ease of referral and communication within such a setting would be much further enhanced by the factor of prepayment, which eliminates the financial barrier for all those who can afford health insurance. For many reasons, then, this setting provides both the impetus and the opportunity to attempt an integration of psychiatry into general medical practice and to observe the outcome. In the past two decades, medicine has been changing in many significant ways, among which are prepaid health insurance, group practice, increasing specialization, automation, and a focus on the "whole person" rather than on the "pathology."

Forsham [7] and others have suggested that at some not-too-distant date the patient will go through a highly automated process of history, laboratory procedures and physical tests, with the doctor at the end of the line doing a physical examination but occupying mainly the position of a medical psychologist. He will have all the results of the previously completed examinations which he will interpret for the patient, and he will have time for listening to the patient, if he wishes to do so. The "Multiphasic Health Check," [4] which has been used for many years in the Northern California Region in the Kaiser Foundation Medical Clinics and which is constantly being expanded, is just such an automated health survey, and Medical Group doctors are in the process of becoming continually better psychologists. Eventually many more of the patients who are now seen in the psychiatric clinic will be expertly treated in the general medical clinics by more "complete physicians."

A study such as this raises more questions than it provides answers. One question alluded to above is whether, with an ongoing training program such as Balint has conducted for general practitioners at Tavistock Clinic, internists might not be just as effective as psychiatric personnel in helping a greater percentage of their patients. A training seminar such as this has been conducted by Dr. Edna Fitch in the department of Pediatrics of Permanente Medical Group in San Francisco for many years and has been effective in helping pediatricians to treat, with more insight and comfort, emotional problems of children and their families and physical disorders which are an expression of emotional distress.

Using a broader perspective than the focus on the clinical pathology, one can wonder what social, economic or cultural factors are related to choice of symptoms, attitudes toward being "sick" (mentally or physically), attitudes toward and expectations of the doctor, traditions of family illness superstitions relating to bodily damage, child raising practices, etc. How often is the understanding of such factors of crucial importance for effective and efficient treatment for the patient? Of special interest in general medical practice and overlooked almost routinely by physicians (and by many in the psychological field) are the "anniversary reactions" in which symptoms appear at an age at which a relative had similar symptoms and/or died.

Health Plan statistics indicate an increase in medical utilization with increasing age in adults. This is consistent with the relatively flat curve seen in the "medical utilization" of the control sample over the six year period and is in marked contrast to that of the experimental sample. There is the implication in this that some of the increasing symptoms and disability of advancing years are psychogenic and that psychotherapeutic intervention may in some cases function as preventive medical care for the problems associated with aging as well as preventive medicine in children.

A certain percentage of the long-term psychotherapy group seems to continue without diminution of number of visits to the psychiatric clinic; these patients appear from the data to be interminable or life-long psychiatric utilizers just as they had been consistently high utilizers of non-psychiatric medical care before. They seem merely to substitute psychiatric visits for some of their medical clinic visits. A further breakdown of the long-term group into three parts, e.g., less

than 50, 50 to 150, and more than 150 visits, would probably help to sort this population's utilization into several patterns. More precise data on these groups would suggest modifications in classifications and methods of therapy or might suggest alternatives to either traditional medical or traditional psychiatric treatment in favor of some attempt to promote beneficial social changes in the environments of these chronically disturbed people.

Sources of criticism

(1) one problem in providing a control group comparable to an experimental group in this kind of study is that, although undoubtedly having emotional distress, and in a similar "quantity" according to our yardstick, the control group did *not* get to the psychiatric clinic by either self- or physician referral. The fact that the control patients had not sought psychiatric help may reflect a more profound difference between this group and the experimental group than is superficially apparent. One cannot assume that the medical utilization of this control group would change if they were seen in the Psychiatric Clinic. (This objection will be minimized in the "prospective" part of this study, which will be reported in another paper.) Although the average inpatient utilization for the three combined psychotherapy groups is the same as that of the control group in the year before (1959), the inpatient utilization of the long-term psychotherapy group is two and a half times that of the control group. If the study were extended to several years before, rather than just one year, it would become evident whether this was just a year of crisis for the long-term group or whether this had been a longer pattern of high inpatient utilization.

(2) Patients who visit the psychiatric clinic may, for one reason or another, seek medical help from a physician not associated with the Medical Group so that his medical utilization is not recorded in the clinic record, the source of information about utilization. In the long-term-therapy group the therapist is usually aware if his patient is visiting an outside physician, and although it is an almost negligible factor in that group, there can be no information in this regard for the one-session-only and brief-therapy groups without follow-up investigation.

(3) There is no justification in assuming that decreased utilization means better medical care, necessarily. Criteria of improvement would have to be developed and applied to a significantly large sample to try to answer this important question.

(4) Patients may substitute for physical or emotional symptoms behavioral disturbances which do not bring them to a doctor but may be just as distressing to them or to other people.

(5) The "unit" of utilization cannot be used as a guide in estimating costs, standing as it does for such diverse items. In itself the units are not an exact indicator of severity of illness nor of costs. A person with a minor problem may visit the clinic many times, while a much more severely ill person may visit the clinic infrequently. Even more striking is the variation in the cost of a unit, varying from about a dollar for certain laboratory procedures to well over a hundred dollars for certain hospital days (with admissions procedures, laboratory tests, x-rays, consultations, etc.) each worth one "unit." To arrive at an approximation of costs, the units have to be retabulated in cost-weighted form.

Suggested further studies

(1) The question of treatment of patients by non-medical professional clinicians has been argued for more than a half century. It is generally recognized that there are not enough psychiatrists now and that there will not be enough in the foreseeable future to treat all those persons who have disabling emotional disorders. In the late President Kennedy's program for Mental Health this lack was recognized; the recommendation for professional staff for community Mental Health Centers included clinical psychologists, psychiatric social workers and other trained personnel. Having little distinction in our psychiatric clinic between the various disciplines as far as their functions are concerned, it would be feasible and interesting to compare therapeutic results of the disciplines as well as individuals with various types of patients and various types of psychotherapy.

(2) Is length of treatment correlated with diagnostic category, original prognosis by therapist, socio-economic level of patient, discipline and orientation of therapist, or "severity of pathology"?

(3) What happens to the spouse, parents, and children of the patients who are seen in psychiatry?

(4) Are there distinguishing patterns of complaints in the three psychotherapy groups?

(5) How do blue-collar patients differ from white-collar or professional patients in number of interviews, diagnostic label, use of medication, recommendation of hospitalization, and type of complaints?

(6) What is the nature of the illness that resulted in hospitalization before the patient came to psychiatry—and after? How often was this a diagnostic work-up because the internist could not find "anything wrong" in the clinic?

SUMMARY

The outpatient and inpatient medical utilization for the year prior to the initial interview in the Department of Psychiatry as well as for the five years following were studied for three groups of psychotherapy patients (one interview only, brief therapy with a mean of 6.2 interviews, and long-term therapy with a mean of 33.9 interviews) and a control group of matched patients demonstrating similar criteria of distress but not, in the six years under study, seen in psychotherapy. The three psychotherapy groups as well as the control (non-psychotherapy) group were high utilizers of medical facilities, with an average utilization significantly higher than that of the Health Plan average. Results of the study indicated significant declines in medical utilization in the psychotherapy groups when compared to the control groups whose inpatient and outpatient utilization remained relatively constant. The most significant ones occurred in the second year group of the initial interview, and the one-interview-only and brief-therapy groups did not require additional psychotherapy to maintain the lower utilization level for five years. On the other hand, after two years the long-term psychotherapy group attained a level of psychiatric utilization which remained constant through the remaining three years of study.

The combined psychiatric and medical utilization of the long-term therapy group indicated that for this small group there was no over-all decline in outpatient utilization inasmuch as psychotherapy visits seemed to supplant medical visits. On the other hand, there was a significant decline in inpatient utilization, especially in the long-term therapy group from an initial utilization of several times that of the Health Plan average, to a level comparable to that of the general adult Health Plan population. This decline in hospitalization rate tended to occur within the first year after the initial interview and remained generally comparable to the Health Plan average for the five years.

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EFFECT OF A SHORT-TERM OUTPATIENT PSYCHIATRIC THERAPY BENEFIT OF THE UTILIZATION OF MEDICAL SERVICES IN A PREPAID GROUP PRACTICE MEDICAL PROGRAM

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A pilot study was conducted to measure the effect of a short-term outpatient psychiatric therapy benefit on the utilization of general medical services at Group Health Association of Washington, D.C. (GHA), a prepaid group practice medical program. The study group consisted of 256 patients who were referred for such outpatient therapy and who were GHA members for a full 12-month period both before and after the psychiatric referral. Study patients experienced a marked reduction during the year after referral as compared with the prior year in the utilization of GHA nonpsychiatric physician services and laboratory or X-ray procedures. The reduction in number of patients seen was 13.6 percent for nonpsychiatric physician services, and 15.7 percent for laboratory or X-ray procedures. In terms of visits made, reduction was approximately 30 percent for each of these services. Basic findings of reduced utilization was still obtained when factors of age, race, sex, psychiatric diagnosis, and number of therapy sessions attended under benefit were taken into account. Results support findings of reduced utilization in other studies and suggest more efficient utilization of appropriate medical services as a result of short-term outpatient mental health benefit in prepaid health plan settings.

Only in the past decade have significant increases in mental health benefits been included in the rapid growth in health insurance protection through private voluntary insuring organizations. Since 1963, the National Institute of Mental Health (NIMH) has actively stimulated this development of encouraging the expansion of private voluntary health insurance coverage for mental health. [5] In a collaborative effort with the NIMH, the United States Civil Service Commission, which administers the Federal Employees Health Benefits program, requested insurance carriers and health plans participating in that program to incorporate new or improved mental health benefits, particularly coverage for outpatient services, into their existing benefit structures.

A total of some four million people are enrolled in community prepaid group practice health plans which are essentially comprehensive in their health coverage. [6] Prior to 1960, when the federal employees program went into effect, these plans in the main were without prepaid mental health benefits. However, all federal employees enrolled in these plans now have some mental health coverage, including outpatient benefits; and similar coverage is also available to other members and contractor groups in these plans.

With the adoption of mental health benefits in prepaid group practice plans, it has become possible to evaluate to some extent the effects that these benefits might have on patient utilization of nonpsychiatric medical services covered by the plans. [1, 2] Group Health Association of Washington, D.C. (GHA) cooperated with the Biometry Branch of the NIMH in conducting a small pilot study directed towards this question. This paper reports on the results of that study which is based on the first year's experience with a mental health benefit at GHA before benefits were expanded and before the total population of GHA was included.

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† The Federal Employees Health Benefits program, which became effective in 1960 under an Act of Congress, is the largest employer-sponsored contributing health insurance program in the world covering more than seven million persons, including employees, annuitants, and dependents.

SETTING AND NATURE OF SHORT-TERM MENTAL HEALTH BENEFIT

The Group Health Association of Washington, D.C. is a comprehensive prepaid group practice program whose participating population resides almost entirely in the metropolitan Washington, D.C. area and is comprised of three groups: federal government employees, D.C. transit workers, and general members. In November 1964, GHA included a limited outpatient mental health benefit in its structure of benefits for its government employee group who then comprised 66 percent of the GHA participant population of approximately 54,000. In January 1965, this benefit was extended to the general members who accounted for 18 percent of the participant population. Thus, 84 percent of the GHA population had some coverage for short-term outpatient psychiatric care at the inception of the partially prepaid benefit. Acute short-term hospital care had previously been part of the benefit structure.

At its initiation, the GHA mental health benefit offered under prepayment was essentially as follows: GHA paid up to 15 dollars for each of 10 therapy sessions in a membership-year for outpatient treatment of acute mental illness and emotional disorders subject to significant improvement through short-term outpatient therapy.¹ A GHA screening psychiatrist determined eligibility for referral on benefits. When the patient was referred by a GHA nonpsychiatric physician to the GHA screening psychiatrist for evaluation purposes as to eligibility for benefits, there was no charge to the patient for that visit or visits. During the study period, a patient could also self-refer to the screening psychiatrist. An evaluation of the patient's psychiatric condition was made by the screening psychiatrist and, on the basis of his diagnostic impression, he recommended appropriate psychiatric care where indicated, and he determined whether GHA coverage for benefits could be approved. If short-term therapy was authorized under the benefit, the patient was referred to psychiatrists or other mental health disciplines. If the condition was chronic, and hence not covered by the benefit, referral could still be made to another agency or psychiatrist, but no payment would be made by GHA for such care.

STUDY DESIGN

The basic study plan was to compare, for the case group under study, the utilization of GHA medical services before and after each patient was referred on benefits for short-term outpatient psychiatric therapy. The "before" period was the 12-month interval immediately preceding the date of referral by the screening psychiatrist. It was considered likely that virtually all of the patients undergoing therapy would have completed such care during the first three months immediately following referral. Since such therapy was apt to affect the utilization of GHA services during this period, and to allow sufficient time for completion of the therapy on benefits, the "after" period of 12 months' duration was taken to begin three months following the referral date. Thus, the records for each study patient were reviewed for a 27-month exposure period, although the three-month "psychiatric therapy interval" was not to be included in the "before-after" analysis of medical services utilization.

For purposes of the study, it was desirable that the study group be confined to persons who were covered by the same mental health benefit. It was, therefore, decided to limit the study group to all patients enrolled under the "high option" or "premium" plan who were referred on benefits for psychiatric therapy during the first year the benefit structure was in effect.² Thus, as a by-product, the results of the study could provide a baseline for any future studies based on a revised benefit structure. (After the first year, the GHA mental health benefit substantially increased and broadened.) [7]

¹ The limit of 10 therapy sessions was a renewable benefit each membership-year (i.e., year beginning with each anniversary date of joining the plan). Thus, if therapy was initiated towards the end of one membership-year and carried into the next, the patient could actually have as many as 19 sessions for the same referral.

² Under the "low option" or "standard" plan, GHA paid up to 10 dollars (as compared with 15 dollars under "high options") per therapy session. Only about 10 percent of the GHA members are enrolled in the "low option" plan.

Since the GHA mental health benefit during the study period applied only to the federal employee and general member groups (including covered family members), they comprised the study population. The GHA medical records for these enrollees were reviewed by GHA staff to identify all patients who were referred to, and seen by, the screening psychiatrist during the period November 1, 1964 through October 31, 1965, the first full year in which the psychiatric benefit was in effect. To protect the confidentiality of the patient, individuals were not identified by name to the study staff. Also, it should be noted that the confidential psychiatric notes are not part of the medical record and were not made accessible for this study.

A total of 726 patients (excluding GHA staff and dependents) were referred to the screening psychiatrist. Of this total, 409 patients were excluded from the study because they were judged ineligible for coverage under this benefit or because they overtly refused psychiatric care. Specifically, 161 were judged not to be in need and hence not referred for outpatient psychiatric care; 197 were referred for psychiatric care but not on benefits; referral was deferred for 45 patients; and 6 patients who would have been referred on benefits overtly refused to accept such care.

The records for the remaining 317 patients seen by the screening psychiatrist were reviewed for the 27-month period referred to earlier. From this total, 61 were eliminated from the study as follows: 57 cases were not available for the full 27-month period (35 began membership less than one year prior to the date seen by the screening psychiatrist, and 22 terminated their membership within the 15-month period following that date); for four patients the files were not available. This left 256 patients who comprised the study group. Of the final study group, 197 were enrolled in the federal employee program and 59 were general members—approximately in the same ratio to one another that these two groups comprised in the total GHA population.

As point of interest, the age distributions were examined for the 409 patients ineligible for benefits and the 61 eligibles who did not otherwise meet the study criteria. The age distribution for the former group was found to be very similar to that of the 256 study patients; however, the latter group of 61 patients had a somewhat younger age distribution than the final study group.

Data extracted from the medical records were counts of all visits to GHA physicians for medical care, all visits for x-ray and laboratory procedures, as well as the number of visits made for psychiatric therapy under the mental health benefit. Other data abstracted for each patient, where available, were age, race, sex, and psychiatric diagnostic impression. Information on psychiatric and non-psychiatric hospitalizations recorded in the medical record was also extracted. However, study data on hospitalizations were incomplete because such information was not generally recorded on patients who were hospitalized outside of GHA auspices. Also, during the period of study, the GHA hospitalization information was not consistently available in the progress notes which formed the primary source of data for this pilot study.

RESULTS

The distribution of the study population by age, sex, and race is shown in Table 1. Approximately 70 percent of the study group were from 25 to 64 years of age at time of referral on psychiatric benefits. In contrast, only 50 percent of the total GHA participant population (in the federal employee and general groups) were in this age group during the study period. [3] About 60 percent of the study group were female, which was slightly higher than the proportion of females in the total GHA membership. With respect to race, about 83 percent of the study group were Caucasian. Although no precise data on race are available for the total GHA membership, the proportion of Caucasians in the total membership is estimated to have been appreciably less than that in the study group. Specific psychiatric diagnosis for each patient was not uniformly recorded in the medical records. However, from information which was re-

recorded, based on the evaluation of the screening psychiatrist or the psychiatrist providing therapy it was possible to classify the psychiatric diagnostic impression into broad categories for three fourths of the study group. Among those for whom the diagnostic impression was determined, 21 per cent were classified psychotic, 55 per cent psychoneurotic, 11 per cent with personality disorders, 11 per cent as having a transient situational personality disorder, and 2 per cent were considered to have some other psychiatric problem.

TABLE 1.—DISTRIBUTION OF STUDY GROUP BY AGE, RACE, SEX, AND PSYCHIATRIC DIAGNOSTIC IMPRESSION

Patient characteristics	Number	Percent ¹
Total study group	256	100.0
Age group (years):		
0 to 14	22	8.6
15-24	49	19.1
25-44	97	37.9
45-64	82	32.0
65-plus	6	2.4
Race:		
Caucasian	210	82.7
Other	44	17.3
Unknown	2	
Sex:		
Male	100	39.1
Female	156	60.9
Psychiatric impression:		
Psychosis	40	20.7
Psychoneurosis	106	54.9
Personality disorder	21	10.9
Transient situational personality disorder	22	11.4
Other	4	2.1
Unknown	63	

¹ Based on total patients for whom characteristics were known.

Initially, the data were analyzed separately according to the specific medical department or ancillary service in which the patients were seen (i.e., internal medicine, other nonpsychiatric medical department, laboratory, x-ray). Almost 95 per cent of the visits by the study patients for physician services were made to the department of internal medicine. However, since the study findings for visits to internal medicine were similar to those for other non-psychiatric medical departments, the data for all medical departments were combined in the analysis presented here. Similarly, with respect to ancillary services, the findings on visits for laboratory procedures were essentially the same as those for x-ray visits, so the data for laboratory and x-ray services were also combined.

Study findings presented below compare separately the physician and ancillary (laboratory or x-ray) services received by the study group during the 12-month periods before and after referral on psychiatric benefits, by age, race, sex, diagnosis, and number of psychiatric therapy sessions attended on benefits. It was not possible to conduct a "before-after" analysis with respect to utilization of psychiatric services. Although some psychiatric counseling was provided on a fee-for-service basis prior to the initiation of the mental health benefit, there was no psychiatry department as such at GHA at that time and, therefore, no comparable or meaningful basis for comparison. Thus, the "before-after" analysis was limited to utilization of nonpsychiatric medical services.

Table 2 shows the number of study patients who received care from the various GHA departments, except psychiatry, and the number of visits made to these departments during the "before" and "after" periods. Also shown is the per cent decrease from the "before" to the "after" period with respect to number of patients seen and number of visits made. Each visit for laboratory or x-ray services was counted only once regardless of the number of procedures performed at each visit.

TABLE 2.—COMPARISON OF NUMBER OF PATIENTS SEEN AND VISITS MADE DURING YEAR BEFORE AND YEAR AFTER PSYCHIATRIC REFERRAL BY TYPE OF SERVICE

Type of service (nonpsychiatric)	Patients seen (N=256)			Visits made ¹		
	Year before referral	Year after referral	Percent change	Year before referral	Year after referral	Percent change
Physician services.....	243	210	-13.6	1,264	876	-30.7
Laboratory or X-ray.....	210	177	-15.7	795	558	-29.8

¹ Each visit for laboratory or X-ray services was counted only once regardless of the number of procedures performed at each visit.

It is clearly evident from these data, in terms of persons seen and visits made, that medical and ancillary services were each provided to more of these patients and more frequently before psychiatric referral than after. Thus, the reduction in the number of patients seen by the nonpsychiatric medical departments was 13.6 percent, and for laboratory or x-ray procedures, 15.7 per cent. Similarly, in terms of number of visits made, the reduction was approximately 30 per cent both for physician services and for laboratory or x-ray procedures.

Viewing the reduction in utilization another way, the average (mean) number of visits made by the 256 study patients, during the "before" and "after" periods, respectively, were 4.94 and 3.92 for physician services, and 3.11 and 2.18 for laboratory or x-ray procedures.

Overall, the study group experienced a total reduction of some 30 per cent in the number of visits made for physician and ancillary services. The difference between the periods before and after referral with respect to the number of patients seen was statistically significant ($P<.001$)³ for physician services as well as for laboratory or x-ray procedures. Similarly, for each of these services, the reduction in the mean number of visits was also statistically significant ($P<.001$).⁴

The study data were analyzed further to determine whether the observed decreases after psychiatric referral held for various subgroups of the study population. Thus, for both physician services and ancillary services, the "before" and "after" periods were compared with respect to the per cent change in number of persons served and total visits made according to age, race, sex, psychiatric diagnostic impressions and number of psychiatric therapy sessions attended under benefit.

The findings presented in Table 3 clearly show the overall consistency of reduction in utilization of the physician and ancillary services by the study group. Although some variation existed in the extent of decrease (partly due to small numbers in some cells), the pattern of reduced utilization of these services held throughout each of the distributions.⁵ There was particularly little variation in the per cent change by age. It is also of interest to note that patients who did not avail themselves of the short-term outpatient therapy benefit generally showed as great a relative reduction in utilization of medical services as did those who received the full benefit of at least 10 sessions.

³ McNemar's chi-square test for correlated samples was used.

⁴ The two-tailed t-test of paired (before-after) differences was used.

⁵ For both of the service categories, statistical tests of significance were performed comparing the various age groups, Caucasians with those of other races, males with females, the various diagnostic categories, and those who had no psychiatric therapy sessions under benefit with those who had 10 or more sessions. With respect to persons seen, each patient was classified as to whether or not he showed a "before-after" reduction in number of visits made, and a chi-square test was used to compare the dichotomous distributions for the various comparison groups. None of these comparisons was significant at the .05 levels. With respect to visits made, either an analysis of variance or a two-tailed t-test was made of the difference between the comparison groups in the mean "before-after" reduction in number of visits. In only one instance (the greater reduction observed among males than females in average number of laboratory or X-ray visits, $P<.02$) was the observed difference statistically significant at the .05 level.

TABLE 3.—PERCENT DECREASE DURING YEAR AFTER REFERRAL AS COMPARED WITH PRIOR YEAR UTILIZATION OF NONPSYCHIATRIC PHYSICIAN SERVICES AND LABORATORY OR X-RAY PROCEDURES, ACCORDING TO PATIENT CHARACTERISTICS AND PSYCHIATRIC THERAPY ON BENEFITS

Patient characteristics and therapy received	Number in study	Percent decrease after referral ¹			
		Patients seen		Visits made	
		Physician services	Lab or X-ray	Physician services	Lab or X-ray
Total study group.....	256	13.6	15.7	30.7	29.8
Age (years):.....					
0 to 14.....	22	4.5	21.1	23.8	35.6
15 to 24.....	49	17.4	15.8	36.1	33.0
25 to 44.....	97	16.5	17.9	29.7	27.4
45 to 64.....	82	11.5	13.0	31.7	30.8
65 and over.....	6	-----	-----	20.6	20.0
Race:.....					
Caucasian.....	210	13.1	15.9	26.1	30.5
Other.....	44	14.0	14.7	49.0	25.6
Unknown.....	2	-----	-----	-----	-----
Sex:.....					
Male.....	100	16.1	23.5	37.8	47.6
Female.....	156	12.0	10.9	26.0	18.0
Psychiatric impression:.....					
Psychosis.....	40	25.0	28.6	35.0	29.0
Psychoneurosis.....	106	10.0	6.7	23.4	23.3
Other.....	47	4.4	12.2	46.9	32.2
Unknown.....	63	19.0	26.7	24.7	41.5
Psychiatric therapy sessions:.....					
None.....	70	16.9	24.1	39.2	22.6
1 to 9.....	75	12.7	18.5	30.4	23.8
10 or more.....	104	11.0	6.0	23.3	35.3
Unknown.....	7	-----	-----	50.0	44.4

¹ Percent not shown in any cell where base (number before referral) was less than 10.

Another indication of the consistency of reduced utilization of physician and ancillary services after psychiatric referral is evident in the data in Table 4. Here, a determination was made as to whether each patient made fewer, more, or the same number of visits during the 12-month period after psychiatric referral as he or she made during the prior year for physician services or for laboratory or x-ray procedures. Only about one fourth of the study patients made more visits for physician services after referral than before in contrast with the almost 60 percent who made fewer visits after referral. Similarly, only 28 percent of the patients made more visits for laboratory or x-ray procedures after referral than before, while 52 per cent made fewer such visits. Both of these differences were statistically significant ($P < .001$).⁶ When the patients were grouped according to the actual number of visits made in the year preceding referral, this pattern of fewer visits held for virtually all groups of patients who had at least two visits in the prior year for physician or ancillary services. The greatest relative reductions occurred among those who made the most visits during the prior year. Thus, of the 81 patients who made more than five visits for physician services during the year preceding referral 64 (79 per cent) made fewer visits in the post-referral year than they did in the prior year.

TABLE 4.—NUMBER AND PERCENT OF PERSONS WITH FEWER, SAME, OR MORE VISITS IN YEAR AFTER REFERRAL COMPARED WITH YEAR PRECEDING REFERRAL, BY TYPE OF SERVICE

Visits before and after referral	Physician services		Laboratory or X-ray	
	Number	Percent	Number	Percent
Total study group.....	256	100.0	256	100.0
Fewer visits in year after referral.....	152	59.4	134	52.3
Same number of visits both years.....	42	16.4	50	19.5
More visits in year after referral.....	62	24.2	72	28.1

⁶ The chi-square test was employed to test the equality of the number of patients showing a decrease in number of visits with those showing an increase.

DISCUSSION

The consistent results of this pilot study clearly indicate that the short-term outpatient psychiatric benefit at GHA was associated with a decrease in the utilization of physician and ancillary services under the plan. Not only was there a decreased utilization following psychiatric referral for the study group as a whole, both with respect to the number of persons seen and the number of visits made, but this decreased utilization held—to a greater or lesser degree—for all subsegments of the population studied.

Of some interest in this regard is the relationship between utilization of physician and ancillary services at GHA and the number of therapy sessions attended under the short-term psychiatric benefit. Note has been made of the fact that the study patients who did not attend any outpatient therapy sessions under benefits (although referred by the screening psychiatrist for such care) showed as great a relative reduction of medical services utilization as did those who received all or part of their authorized therapy. This finding would seem to imply that the visit to the screening psychiatrist alone may have had a beneficial effect on the patient, at least to the extent that the patient apparently had reduced need or desire for physician or ancillary services following the screening. However, it should be noted that some patients referred on benefits may have elected to obtain their psychiatric therapy outside the GHA benefit structure at their own expense. Unfortunately, the GHA records do not ordinarily reflect such outside care. In any event, it is clear that whether or not the referred patients as a group actually availed themselves of the benefit provisions, they showed a reduced subsequent utilization of general medical services provided by the group practice plan.

It is reasonable to assume that the observed reduction in utilization of physician and ancillary services at GHA to a large extent reflects a reduced need or desire for such services, rather than a shift by the patients to other sources for their medical attention at additional cost to themselves (although, undoubtedly, some such shifting did occur). This assumption is based upon the fact that these patients continued to maintain their GHA membership throughout the 27-month study period, and that the very great majority did return to GHA for at least some medical attention during the "after" period.

When viewed in terms of the effect on the provider of services, the reduction in use of physician and ancillary services at GHA would seem to imply a reduction in cost which would otherwise occur in the provision of such services and, theoretically, a more efficient utilization of appropriate services. There was no attempt to do any cost-benefit analysis in this study, the primary purpose of which was directed at utilization without regard to costs. However, an inference could be made that the cost savings due to reduced utilization would be reflected in the entire benefit structure without setting forth dollar amounts.

Comments should be made about the possible effect of hospitalization on the study findings, since a question might be raised as to whether or not there was appreciably more hospitalization in the period after psychiatric referral than in the prior-referral year. As mentioned previously, during the period of study, the GHA hospital records were not totally coordinated with the medical record, which was the principal data source for this study. Therefore, the effect of episodes of hospitalization on the study findings could not be evaluated. With respect to psychiatric hospitalization, however, since the study group excluded all patients whom the screening psychiatrist considered to have a chronic condition requiring inpatient or long-term outpatient psychiatric care, it is very unlikely that more than a handful of study patients would have required such hospitalization. In any event, the study findings were of such magnitude and consistency that they are unlikely to be materially affected by the factor of hospitalization.

Another consideration relates to the study design whereby each patient was used as his own control in the "before-after" comparison. The absence of a suitable control group in this pilot study, against whom the "before-after" findings of the case group could be compared, limits the conclusions which can be drawn at this time; however, efforts are underway in a broader study to obtain similar data for such a comparison group. The question which arises here is whether the study patients, having already received medical attention one year, would be likely to require more or less care in the following year. If need for less care were

to be expected, this might account, at least in part, for the reduction in utilization observed among the study group. However, the GHA experience in the past indicates that patients using the plan, with its emphasis on preventive services and early detection of chronic disease, tends to use the services increasingly in subsequent years. This is supported by the following data for the total GHA experience around the study period, which show a level or rising per capita utilization in contrast to the observed finding of markedly reduced utilization by the study group. [3, 4]

	GHA per capita utilization		
	Office consultations	Laboratory	Radiology
Year ending Sept. 30:			
1963.....	3.65	3.88	1.08
1964.....	3.77	4.43	1.08
1965.....	3.77	5.06	1.14
1966.....	3.71	5.25	1.12

Follette and Cummings[2] also studied medical utilization before and after psychiatric therapy in a prepaid health plan setting, namely the Kaiser Foundation Health Plan in the Northern California Region. Their case group consisted of persons who received psychotherapy defined as any contact with the plan's department of psychiatry. The medical utilization for the year prior to the initial contact with that department was compared with the utilization for each of five subsequent years, both for the case group and a matched control group who did not receive psychotherapy. The outpatient medical services in that study included visits to outpatient medical (nonpsychiatric) clinics and contacts for outpatient laboratory and x-ray procedures; however, these three types of services were lumped together in the analysis. Despite differences in the setting, benefit structure, mental health disciplines utilized, and study design from those of the GHA study, Follette and Cummings also found a significant decline in utilization of medical services following psychotherapy.

A further, although limited, indication of reduced utilization of general medical services following outpatient psychotherapy is contained in an unpublished report of another study. In 1965, the Health Insurance Plan of Greater New York (H.I.P.) instituted, as a demonstration project, a mental health service which, upon referral by a group physician, provided an outpatient psychiatric treatment benefit in one of its medical groups. One section of the final report of that project[1] submitted by H.I.P. to the National Institute of Mental Health, which partly supported the demonstration project, contains an analysis of the relationship between psychiatric treatment and the use of medical services including family physician office visits, specialist office visits, and x-ray and laboratory services. Due to sample size limitations and other considerations, the results of this analysis were viewed in the report as exploratory only.

The "treatment" group (those seen in the mental health service for consultation or treatment) and three comparison groups were employed in a "before-after" analysis of medical utilization for periods covering one year before the appropriate "study" or "consultation" date and each of two years after. Although the report notes that the analysis did not demonstrate a consistent pattern across all comparison groups, it also states that the analysis indicated "... some tendencies pointing to lower medical utilization in the group to whom psychotherapy was available."

The supporting evidence of the Kaiser, H.I.P., and GHA studies strengthens the hypothesis of reduced utilization of medical services, and more efficient utilization of appropriate services, as a result of a short-term outpatient mental health benefit in prepaid health plan settings.

On the basis of the findings of the GHA study presented in this paper, the authors are now initiating a broader study which will include a "before-after" evaluation of the utilization of GHA medical and hospital services by all family members of patients referred on psychiatric benefit and will also employ one or more comparison groups.

ACKNOWLEDGMENTS

The authors wish to thank Mrs. Josephine Tate (GHA) for her assistance in abstracting the study data; Mr. Robert F. Woolson and Mrs. Warnilla Cook (both of the Biometry Branch, NIMH) for their assistance in the analysis; and Mrs. Mildred Arrill (Division of Mental Health Service Programs, NIMH) for her consultation.

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Dr. DAVIS. The problem about the general hospital psychiatric units, two problems really, I see. They are more expensive because the psychiatric patient in the hospital bed pays a higher rate since that hospital also has to use the psychiatric patient to cover other expensive services, like cobalt machines, operating rooms, and emergency rooms. In a free-standing psychiatric hospital you do not have these higher costs to average out.

The other problems seem to be general hospitals are not comprehensive. A general hospital psychiatric unit tends to be much less comprehensive and not offer a full range of services, such as a day hospital or outpatient treatment or halfway houses.

These cheaper service delivery modules are available through many free-standing psychiatric facilities, but not generally through general hospital psychiatric units.

Senator DOLE. How do you classify drug addicts? Are they classified as psychiatric patients?

Dr. DAVIS. Generally, yes. There is also a medical component. These people usually need to be detoxified. As they withdraw from the drug, they are high-risk. Usually both a specialist in internal medicine and a psychiatrist will initially treat the patient. Once he is detoxified and out of danger physically, the psychiatrist takes over the treatment.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, Doctor. We appreciate your contribution to our deliberations.

The next, and final, witness is Mr. James M. Hacking, assistant legislative counsel, National Retired Teachers Association, American Association of Retired Persons.

If you will insert your statement in full in the record and summarize it, we would appreciate it.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. On my left today is a consultant of ours, Mr. Ralph W. Borsodi. If you will permit, I will proceed to the summary of my statement.

While we generally endorse S. 1470, we expect that the health care cost savings that would accrue from the implementation of its reforms would be far too little—if there are any at all—and would come far too late for our associations to consider it an adequate remedy for the problem at hand.

If the health care system is inevitably going to evolve into one in which provider operation and resource allocation are closely controlled, regulated and funded by the Federal and State governments, then we look upon S. 1470 as a bill to effect the type of long-term structural reforms in payment procedures that will be necessary and consistent with this trend.

We shall not burden the subcommittee with a description of how things work in the health sector or what it is currently costing or what it is expected to cost in the future if it remains unchanged nor do we intend to recite the calamitous consequences if present trends are allowed to continue. We would simply say that if we continue to feed our national resources into the health care industry at the escalating intake rate that has come to prevail, then other priorities like military protection, education and training, income maintenance, tax reform and relief and health benefit program expansion must suffer.

The magnitude of the crisis in health care grows with each day that the status quo in this economic sector is perpetuated. That is why our associations have since the expiration of the economic stabilization program in mid-1974, consistently advocated, in every forum available to us, the reimposition of sectorwide controls. Despite all the bad things that can be said about a controls program, we consider it the only potentially effective instrument available for achieving significant health care cost savings quickly and arresting the exorbitant inflationary trend.

As you might guess, we have strongly endorsed the administration's Hospital Cost Containment Act. Although we wish it were broader in scope and stronger than it is, we still urge its speedy passage. We recognize that it is not a long-term or permanent solution to the cost-escalation problem in health care. All it can do is "buy time" that is necessary to develop and implement structural reform.

With these thoughts in mind, we would like to turn now to S. 1470. First, if we are to continue along the road toward a full Government controlled and regulated health care system, then the development and implementation of a prospective budgeting and rate setting procedure for hospitals and other institution providers is essential. Cost reimbursement is quite out of the question. To the extent that the provisions of S. 1470 proceed in this direction, they have our support.

However, based on past experience, it seems very doubtful that the system of prospective budgeting for routine operating costs can be im-

plemented within the bill's time frame. The development of the necessary uniform cost accounting procedures is going to impede implementation and delay the accruing of any savings that might result from the new system.

This is why we do not consider S. 1470 an alternative to the administration's proposal.

The savings that might be effected through the prospective budgeting of the bill are likely to be rather minimal—especially compared with the Nation's hospital bill of \$55.4 billion—for two reasons: First, the prospective budgeting would only affect the "motel" component of hospital costs. Second, since the payment standards would be set by averages for similar hospitals, the limits would apply only to those hospitals within a group whose costs inflate far faster than those of the group as a whole. Therefore, if hospitals as a group continue to have costs rising far in excess of the general rate of inflation in the economy, there is really no limit and no savings.

Second, with respect to the provisions for practitioners reimbursement reforms—the \$1 cost saving allowance, the concept of participating physician, and the priority that would be given to the payment of their claims—we view them as needed and welcomed incentives. However, we do not think they will be adequate to reverse the declining rate of assignment acceptance by physicians under medicare. We have greater hopes for the development and implementation of an negotiated fee schedule procedure. Perhaps the proposed relative value schedule will have a greater impact.

Third, since our associations believe that the dissemination of information protects the public and promotes competition, we oppose section 44.

Finally, with respect to section 3 of the bill, our associations believe that the transactional allowances would be helpful in promoting the closing down or conversion of underutilized hospital capacity. Certainly, there should be no question that the incentives build into our present health system—with the active cooperation of the Federal Government through its subsidies, tax credits, and reimbursement methods—stimulated that overbuilding of institutional capacity resulting in an estimated excess of 100,000 hospital beds. We doubt, however, that the remedy is adequate for the problem.

To summarize our comments on the bill, then, we would say that because it contemplates structural reforms and would use incentives as a means of achieving them, it has our association's support. Unfortunately, it seems to ignore the use of the pricing system as a means of promoting self regulation in the industry and holding down rates of price increases. It proceeds in the wrong direction on the issue of disclosure and it is not aggressive enough in promoting the closing or conversion of underutilized facilities.

The Government is either going to have to make greater use of the pricing system in health care or it is going to assume the burden of administering an increasing proportion of the industry's operation out of Washington and the State capitals. The latter is the course we have been following; this we think has been a major factor contributing to an escalation of health costs beyond all reason and the acceleration of the rate of commitment of this country's resources to the

duplication of unnecessary and wasteful health care facilities—especially hospitals.

To correct this before we drift into a totally Government controlled and regulated industry or, worse, a total Government owned and operated industry, it is necessary to reverse much of the economics of the health care industry as shaped by Government policy over the last 25 years.

Tax expenditures should not heavily favor growth and expansion of the highest cost segment of the health care industry—namely hospitals—by allowing tax deductions to corporations for insurance policies that are written such that the patient and his doctor have incentives to seek out adequate, but cheaper, facilities for treatment.

Tax subsidies and Federal funds should be totally turned off in areas where hospitals have been overbuilt. Indeed, our associations would go further and propose that a Federal agency purchase the excess hospital facilities and equipment, thereby immediately relieving hospitals of their obligations to carry the excess investment and in the process terminate the wasteful cost of maintaining excess beds.

The Federal Government should provide assistance to foster the development of competing and less costly facilities as community health centers, HMO facilities and ambulatory facilities of all kinds.

The bias of the medicare/medicaid programs in favor of using hospital facilities must be removed. The same bias in the insurance plans for Federal, State, and county and municipal employees must also be removed because the effect is the same—to overutilize hospital facilities. The more we spend on hospitals, the less is available to spend on less costly alternatives.

Because we desire to see greater use made of the pricing system, we favor greater disclosure. It is a necessary adjunct. If more than 50 percent of the income of an institutional provider is obtained from third party payers, the public, it seems to us, as a majority partner is entitled to the fullest disclosure. We feel that a provider falling in this category should publish, or make available to any citizen so requesting, a schedule of compensation of all kinds made to its highest-paid employees.

Hospitals and other institutional providers should provide concerned citizens on request a detailed conflict-of-interest statement for any members of their controlling or administrative staffs who are in a position to influence purchasing, leasing, and contracting.

Conflict-of-interest statements should list investments, holdings, and family ties for such parties with concerns doing businesses with the provider.

In conclusion, Mr. Chairman, our associations believe private initiative stimulated by the pricing system subject to governmental restraints to control abuse will lead to the best health care for the least money. Clearly, some elements in the health care system will never be competitive. But there are many alternatives to health care which, in an economics sense, offer what is called product competition.

However, if it is already too late for the things we are suggesting and we are inevitably heading down the road toward a totally Federal and State controlled and regulated health care system, then prospective budgeting and rate setting procedures for institutional providers and

negotiated fee schedule procedures for licensed professional practitioners are going to be necessary. We welcome S. 1470 as a step in the development of such procedures.

Senator TALMADGE. Thank you very much, Mr. Hacking, for your contribution.

Do you have any questions, Senator Dole?

Senator DOLE. I have no questions, but you raise an interesting point on page 7 with reference to disclosure—there is such an input of Federal funds—I am not certain how much the public really knows about conflict of interest. We see these things develop in investigations from time to time, but it is a point that I had not noted, and had not been raised before and I intend to pursue it.

Senator TALMADGE. Thank you very much.

[The prepared statement of Mr. Hacking follows:]

STATEMENT OF JAMES M. HACKING OF THE NATIONAL RETIRED TEACHERS
ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, I am James M. Hacking, the Assistant Legislative Counsel for the 11 million member National Retired Teachers Association/American Association of Retired Persons. With me today is Ralph W. Borsodi, a retired economist and health economics consultant to our organizations.

Since our members are regular customers of health care providers, our Associations have a broad interest in the health care industry. We are concerned with the direct and indirect cost of services. We are concerned with quality of care and relating the industry to the overall problems of health. We are troubled by problems of access to health care that many elderly and non-elderly persons, have because of the cost of medical services and because the industry is so structured that they cannot obtain services when and where they need them.

We are here today to endorse S. 1470, the Medicare/Medicaid Administrative and Reimbursement Reform Act. We, are however, troubled by the timing of the bill's reforms and their potential effectiveness. The air has been filled with statistics on the health industry during the past two months; we do not propose to burden this Subcommittee with the same figures. We would assume that you are satisfied that the escalation of costs in the industry has reached a critical point. We are afraid that, if present trends in the health sector of the economy continue, the nation as a whole may be weakened by the diversion of an ever-increasing and perhaps excessive amount of precious resources to the health care industry.

The failure to choose between guns and butter in the mid 1960's laid the foundation for the permanent price inflation from which we are now suffering. We now face another choice. If we continue to feed our national resources into the health care industry at its customary intake rate, then other priorities such as military protection, education and training, and income maintenance for the elderly and the poor must suffer. We shall also have to forego improvements which might be made in health care and in the support programs for the elderly and the poor. The nation's resource "pie" is only so big. If we refuse to deal resolutely with the problem of escalating costs in the health sector, we run the risk of encountering economic consequences no less serious than the consequences which followed our failure to meet the guns and butter issue of the sixties.

We share Senator Talmadge's concerns with respect to the Administration's proposal to contain hospital costs. The cap proposed may not be effective. Switching from caps on reimbursements to budgeting restraints may seriously disrupt the industry. The efficient elements in the industry may be hurt and the inefficient rewarded.

Nevertheless, early action is needed and the action taken must afford some relief. Some time must be gained to consider and to promote alternatives which may be more promising than various forms of budgeting restraints. The reimbursement restraints on providers under the Medicare formula for allowable

costs were originally intended not to be not unduly restrictive so that Medicare could get on its feet. But, the continuation of the allowable cost formula for a decade, long after the program's implementation, has been an economic calamity. This cost-plus reimbursement has not only contributed to the industry's excessive inflation rate but has distorted the industry in the sense that capital and personnel are flowing into activities with the least pricing restraints. We know that caps on hospital costs will give us only temporary relief. We hope that prospective budgeting will give us measurably more relief than the present system of allocating the past year's budget between classes of patients.

Certainly, there is no novelty in prospective budgeting. It has been widely used in the private sector the better part of this century; but those who use it treat it as part of a plan to guide future operations that is subject to adjustments for good business reasons. A carefully planned budget is a help in controlling costs. Yet costs are constantly incurred to meet changing activities. Feedback is often slow. If costs and budget figures coincide, it is usually a happy accident.

HOSPITAL REIMBURSEMENT REFORM

What cost savings may we reasonably expect for hospitals and other providers under the prospective budgeting proposals of S. 1470? If we confine ourselves to hospitals, their numbers make it impractical to set budgets line-by-line, although some state review boards do examine high cost hospital figures in detail. S. 1470 classifies hospitals in groups and then provides for budgeting by these group classifications for routine operating costs, as defined, with fine tuning for geographic wage differentials, and for other specified variations and exceptions. Hospitals would recover their budgeted routine costs, the motel component, via per diem rates. If an institution's actual costs exceed its payment rate by more than 20 percent, there would be a penalty. But an actual cost of less than the payment rate results in a bonus of up to 5 per cent of that rate. The uniform cost accounting procedures required of all hospitals would most certainly make for a lengthy period of phasing in the new reimbursement procedure—possibly as long as two to four years.

Provision would have to be made for the recovery of the bulk of the costs which are not deemed routine in nature; this provision would presumably remain under the present allowable cost formula for Medicare patients. Recovering routine and non-routine costs under two different procedures seems very complicated.

We appreciate that reform takes time, but it seems to us that any savings under prospective reimbursement are too far down the line; they would not begin to accrue until 1980 or 1981. Moreover, hospitals by groups increase their costs at a rate in excess of the general inflation rate in the economy, as in the past, the only savings we could expect would be savings on routine costs by the better managed hospitals in the group. What these savings might be are impossible to estimate with any reasonable accuracy. We believe they would be small compared to the nation's present hospital bill of \$55.4 billion. If we must rely on provider budgeting reimbursement systems, we support a change to prospective budgeting with savings incentives as set forth in S. 1470. However, the situation does not permit delay; strict cost restraints, such as the Administration's proposal contemplates, are immediately needed in the hospital sector.

We support S. 1470 because it would use incentives to accomplish a number of its objectives. But we wonder if the health care industry should not be given strong economic incentives so that it becomes self-regulating to a much greater degree.

We seem now to be drifting toward national health insurance in a sea of regulations. It seems necessary to regulate the health care industry in almost every aspect of its operations. Some of the major areas which at one time or another we have been attempting to regulate are financial accounting, cost accounting and cost reporting, budgeting, profits, depreciation management, professional personnel numbers and characteristics, salaries, wages, expansion of assets and contraction of assets, characteristics of the assets delivering health care, purchasing of equipment, technology used, access to the health care system, quality of care and records relating to patients. We are attempting to run one of the country's largest industries by Federal and State regulation. As soon as one regulation is issued another regulation must be planned to plug the loopholes in its predecessor. Those who regulate are not technically qualified in medicine.

Because the economic consequences of our proliferating controls have been bad, we should try to move in the direction of a health care industry which is more self-regulating, rather than one which is less so.

While our Associations strongly favor the development of a truly comprehensive national health insurance program, private initiative should be preserved, even while assuring that any person needing medical care may obtain it without regard to ability to pay. We think greater progress is made through private initiative rather through public action. We fear that proposals to control health care industry costs by incorporating the total costs of the industry in the Federal budget would only create the illusion of controlling costs and would spawn the need for government ownership and management of the industry.

Although S. 1470 uses incentives, the Subcommittee should consider pricing initiatives in the health care industry as a means of promoting self-regulation. The larger part of industry and commerce in the United States still operates under privately determined prices. Price levels and the ability of an industry to manage its costs lead to private judgments as to whether or not new facilities should be built and what kind of product or services should be offered to the public. Because we still rely on markets and pricing for our economic well-being, we find it curious that in Congress the possibility of self-regulating the health industry by pricing mechanisms has been largely dismissed. The basis for dismissing consideration is that we have evolved a system under which patients other than private patients (who are responsible for their own bills) are completely indifferent to the overall costs of their care. If one does not have to pay more out-of-pocket for a Cadillac, why ride in a Ford?

In order to restore pricing incentives in the health care industry, we need to review practices which have made for indifference to prices. The automobile insurance industry does not accept the highest price in town, when one presents a bill for replacing a damaged fender; the injured party has a strong incentive to find competitive prices. The medical insurance industry should be asked to follow the practices of insurers in other fields and not pay for a ride in a Cadillac, if a Ford will do. This proposal applies not only to choices between hospitals in a town, but also to choices between a hospital and various ambulatory facilities.

Obviously, the doctor will have much to say about these choices, but at least the terms of the insurance should not stifle competition. The public has a great interest in the medical insurance business, because the cost of medical insurance is a deduction in computing taxes on business. If the terms of policies stifle provider competition their costs should not be allowed as a deduction for computing federal income taxes.

Federal and State governments which provide their employees with medical insurance which does not discriminate between low and high cost providers, assist in destroying useful provider competition. The administration of this purchasing for public employees calls for reform. The providers themselves may prefer the cold winds of competition to more regulation.

If providers have a choice between caps on their overall costs, caps on a prospective budget, or self-publishing their rates for billing purposes, we have no doubt that they would opt for establishing their own rates. We think most hospital providers could readily establish and publish rates for the motel portion of their charges. While it would take longer to establish rates per diagnostic stay, this too can and should be done for it would cover the bulk of their charges, leaving only unusual cases for cost-plus reimbursement.

PRACTITIONER REIMBURSEMENT REFORM

The Subcommittee is no doubt aware of the fact that the rate at which physicians are accepting claim assignments of Medicare reimbursements stands at most unsatisfactory levels. In the five year period from 1969 to 1974 it dropped from 61 per cent to 52 per cent. The most recent figure is 50 per cent. While we would hope that the reimbursement reforms and the concept of "participating physician", that are incorporated in S. 1470 would lead to an improvement in the assignment statistics, we have our doubts. We are inclined to think that the "reasonable charge" concept has outlived its usefulness. Since Phase I of the Economic Stabilization Program, physicians fee reimbursement has been under restraint. Although the regulations have become progressively more complicated the "reasonable charge" concept has not prevented physicians from doing very well indeed for themselves. Medicine is regarded as the profession with the high-

est income potential. Physicians have been doing so well, in fact, that it would seem to be in order to cap their fees, along with hospitals, until reimbursement reforms can be instituted.

The problem is how to deal with fee-for-service income, since individual salaries can be determined and subsequently controlled. If the Federal Government would pass adequate disclosure laws covering physicians associated with providers, the excesses which have made headlines from time to time could be routinely cut down. As for fee-for-service income we would propose that the concept of "reasonable charge" be completely dropped and that negotiated fee schedules be substituted. The negotiated fee schedules should be the same for Medicaid and Medicare.

The negotiated fee schedules should be made with as many individual physicians as feasible, because grouping the fees will only lead to elevated rates. Individual rates will reflect, or should reflect, the differences in the cost of operation caused by location, the physician's expertise, and other circumstances. To promote assignment under Medicare, it is recommended that the government assume responsibility for the collection of deductibles and co-insurance payments from the beneficiaries. After experimenting for more than a decade with "reasonable charges" for physicians fees with most unhappy results, the logic is to get off the flypaper of regulation piled on regulation and begin to put more faith in the pricing system that has served us well for the most part.

DISCLOSURE

Our Associations believe that information is a great protection for the public because it promotes competition. But S. 1470 would retreat from rather than advance toward competition. If the list of physicians receiving large payments from Medicare and Medicaid was in error last year we should think that protests should lead to care in making the disclosure, rather than to an abandoning that disclosure.

We are of the opinion that disclosure procedures for providers are inadequate. If more than 50 percent of the revenues of a provider are obtained from third party payers the public is a majority partner and is entitled to the fullest disclosure. To begin with, a provider falling in this category should publish, or make available to any citizen on request, a schedule of compensation, of all kinds, made to highest-paid of their employees. Because of reported past abuses, hospitals should publish, or make available to citizens on request, statements for the latest year available of the receipts of their pathology and radiology departments and the gross income of the physicians in charge of the departments. As for the anesthesiologists, pathologists and radiologists who practice in the hospital, but bill separately, these professionals should be required to disclose their gross and net incomes from such sources.

Hospitals, and other institutional providers, with more than 50 per cent of their revenues from third party payers should provide concerned citizens on request with detailed conflict of interest statements for any members of their controlling or administrative staffs who are in a position to influence purchasing, renting, leasing and contracting. The conflict of interest statements must list all investments, holdings and familial ties for such parties with any concern doing business with the provider.

More detailed suggestions on disclosure were made by Andrew J. Biemiller of the AFL-CIO on May 11, 1977 when testifying before the Health Subcommittees of the Ways and Means and Interstate and Foreign Commerce. Our Associations endorse these disclosure requirements.

INCENTIVES TO ELIMINATE OR CONVERT EXCESS CAPACITY

Our Associations believe that Section 3 of S. 1470 will be helpful in promoting the closing down or conversion of underutilized facilities in hospitals. It has become generally recognized that the incentives in our health care system have led to an overbuilding of capacity resulting in an excess of 100,000 beds. If it costs \$10,000 per annum to maintain an excess bed, we are wasting \$1 billion annually.

We suggest that we retire this excess capacity in a manner more aggressive than that proposed by the bill. It only contemplates retirement adjustments for a limited number of hospitals under the reimbursement formula in the first two years. We propose that a Federal agency purchase the excess facilities and equip-

ment, which would both immediately relieve hospitals of their obligations to carry the excess investment and thus terminate the waste of maintaining the excess beds. In effect, the Federal Government would be reversing the overbuilding which its subsidies, tax credits and reimbursement methods created. (Perhaps the equipment salvaged could be used in areas underserved by medical facilities.)

CONCLUSION

In summary we seem to be moving in a Cadillac toward national health insurance at times, using one or another of three roads as a national health care system:

(1) A heavily regulated system in which the operations are closely controlled by Federal and State governments, as well as the allocation of resources to various types of health care;

(2) A system of health care in which major elements are operated with considerable freedom by persons or by groups of persons and under which much private initiative exists to improve and modify the system; and

(3) A system of health care largely financed by the Federal and State governments, which will be necessarily controlled so that its operations are contained within the budgeting processes of the government.

Our Associations believe that private initiative stimulated by the pricing process and subject to governmental restraint to control abuse will lead to the best care for the least money. Clearly, some elements in the health care system will never be competitive. A single hospital in a town or region cannot be. But there are many alternatives to hospital care which, in an economic sense, offer what is called product competition in general industry and commerce. We may well be headed down the road toward total Federal and State funding of health care. In this eventuality we most certainly would hope that all major units in the health care system embrace sound prospective budgeting practices. We endorse the Subcommittee's bill for these considerations. We have, however, also endorsed the Administration's Hospital Cost Containment Act because we are of the opinion that the cost escalation in the health care sector is so severe that we cannot wait for reformed, reimbursement methods to begin to yield some savings at some point in the future.

APPENDIX B

ADDITIONAL INFORMATION SUBMITTED FOR THE RECORD BY THE BLUE CROSS ASSOCIATION

Because of its public nature and unique role in the community, the Blue Cross organization's performance is, and should be, measured not only in terms of efficiency and effectiveness in processing claims and performing other traditional insurer functions, but also in terms of the level of efficiency and effectiveness of the health care delivery system with which the Blue Cross organization closely interacts. Hence, for the Blue Cross organization, "cost containment" must involve a total focus on the annual level and trends in health care expenditures per Blue Cross Plan member and, more generally, per consumer.

While the Blue Cross organization has a major responsibility to contain health costs, it is clearly a shared responsibility. Health providers, government, labor and business all must work with us to insure success. Hospital trustees, hospital administrators, physicians, and other health professionals must understand the dimensions of the problems and actively contribute to its solution. Physicians are particularly important, for it is they who have the primary professional responsibility to educate the public, decide what services are necessary and appropriate for individual patients, and influence the decisions as to what equipment is purchased and how many facilities are built.

The underlying causes of the health care cost problem can be characterized as two fold. The first cause relates to the lack of a balanced national perspective aimed at allocating resources both within and external to the health care delivery system to achieve health status improvement in the population. There is increasing awareness that no matter how much we as a nation spend on disease treatment and accident repair, it will not make people healthier. In fact, some argue that we have reached a point of diminishing—perhaps negative—returns on our nation's continually growing investment in health care services. Health is influenced by a multitude of factors such as lifestyle, social and physical environment, income, education and nutrition. We must begin to examine the inter-

relationships between health care delivery system initiatives and other factors that influence health, and determine which of those, and in which proportions, will produce the greatest level of real health for the money and resources spent. Obviously, this problem is easier to diagnose than to cure. Its solution lies in the longer term by reducing the need and demand for health care, and by influencing people to accept more responsibility for their own health, thus reducing their dependence on the health care system.

The second cause of the cost problem, for which more immediate solutions are available, relates to existing incentives in the health care system in this country that encourage excessive medical care expenditures, including hospitalization, and other high cost services. Specifically, with regard to acute care hospitals, the incentives tend to expand the quantity and quality of services provided. This, in conjunction with increasing numbers of people with increased coverage for acute care, has led to sharp rises in costs above the rate of inflation or the expansion of the economy as a whole. The principal factors in our health care system which promote accelerating costs are:

Excess supply of facilities and services—In virtually every state examples can be found of underutilized or unnecessarily duplicated services. Since capital costs and services offered are among the major determinants of hospital costs, without effective planning the cost spiral will never be reversed.

Uncontrolled Medical Technology—There is widespread demand for medical innovation often without communitywide cost/benefit analysis.

Medically unnecessary or inappropriate use of services—The average change in rates of admissions and hospital days has been moderated over the past several years. However, alternative health delivery organizations, e.g., HMO's, are still demonstrating significant lower hospital use rates. And, there is wide variance around the average by state, and by region within states. In addition, medical malpractice costs and the increasing practice of defensive medicine appear to be increasing the use of such professional ancillary services as lab and x-ray.

Institutional Productivity—Hospitals represent expensive commitments of capital and human resources. There is evidence that the productivity of these resources can be significantly improved in three ways: by operating at efficient levels of bed and other service capacity, by providing more timely and better coordinated service to permit reduction of length of stay, and by improving the use of personnel. While hospital salaries have increased in the past four years at a level which is commensurate with increases in the cost of living, the number of hospital employees per patient day has also increased.

We believe there are five major approaches that form the basis for implementing an effective, longer term, community-wide cost containment program. They are interdependent, and successful program of cost containment will take all of them into account. Their effective implementation requires the shared responsibility and cooperation of all parties involved. The approach to be emphasized at a particular time or place will depend upon the environment in which Blue Cross Plans and others are working. These approaches are:

(1) **Health Facilities and Service Planning**—This has to be a major factor in the solution to the cost containment problem. Without effective health planning the problems of inefficient and excess capacity and of unnecessary services will never be resolved. Blue Cross Plans should support and participate in planning initiatives at the national, state and local levels, including relating reimbursement to certification, and providing funding, staff support and information where appropriate.

(2) **Provider Payment**—The basis which providers are reimbursed establishes the incentive framework for cost incurrence. Blue Cross Plans should support and participate in the development and implementation of equitable prospective or other incentive payment systems that insure better cost predictability and more efficient and effective institutional operations.

(3) **Utilization Review**—Conceptually, and as it presently exists, U.R. offers many possibilities for cost containment. Basically a quality control tool, it is something that health professionals accept. To contain costs, reviews must be made to insure that the need for patient service exists and that the proper level of care is rendered. Plans should support the activities of hospitals and PSROs, and should monitor their performance. Plans should contribute data sources and advice to these agencies in addition to their own claims reviews.

This may involve concurrent or retrospective review, pre-admission testing or second opinions before surgery, and it may be done in a hospital, skilled nursing facility or on an ambulatory basis or by utilization review committees, PSROs or panels of health professionals.

(4) **Innovative Health Care Benefit Packages**—There is growing evidence that traditional acute hospital care benefits in conjunction with other expanded benefits such as home health care, ambulatory surgery, second opinions in surgery, and pre-admission testing can be an effective cost containment tool when coupled with programs of planning, reimbursement and utilization review. Blue Cross Plans are supporting and experimenting with this approach, particularly in instances where the extension of benefits and services demonstrate potential for decreasing the use of expensive, acute care benefits.

(5) **Alternative Delivery Systems**—The Blue Cross organization already has played a major role in fostering HMO's. Preliminary reports indicate that HMOs are a useful alternative in the market. Although HMOs are not preferred by all, they are an effective influence on the rest of the system. Blue Cross Plans are continuing to develop and evaluate alternative delivery systems.

Dependent upon analyses of local data and local circumstances, the above tools can be expected to have differing priorities at any point in time, and over time. It is important to recognize, however, that for more permanent and effective results, most if not all of these tools must be in place. Just as the cost problem itself has many interrelated facets, so must the solutions consist of a series of coordinated and integrated initiatives. No one tool can in the long run be expected to accomplish the total job that needs to be done.

With the foregoing in mind, we would like to describe briefly the types of specific initiatives being undertaken by the Blue Cross organization to further the development and implementation of the five tools cited above. An additional section is presented on medical technology, as this is indeed a multi-faced problem requiring the simultaneous application of several cost containment tools.

INCENTIVE PAYMENT EXPERIMENTATION

The Blue Cross organization has been more actively involved and for a longer period of time, than any other payer group or government programs aimed at promoting hospital operational efficiency. A variety of approaches are currently being tried by the majority of 69 Blue Cross Plans located in the United States. Generally, the approaches can be grouped as follows:

(1) **Prospective Charges**—involving analysis and negotiations of proposed hospital charge schedules underlying operating and capital expenditure budgets. Examples of Blue Cross Plans involved in this type of approach are those in Kentucky, Indiana, Cincinnati, Ohio, Oklahoma, Wisconsin, and Kansas City, Missouri.

(2) **Prospective Formula-Determined Costs**—involving application of a pre-determined formula, e.g., a target rate approach. Examples of Plans involved in these approaches are those in New York and Pittsburgh, Pennsylvania.

(3) **Prospective Budget-Negotiated Costs**—involving negotiation of individual hospital operating and capital budgets. The Blue Cross Plan in Connecticut has been experimenting with this approach as well as Plans in Wilkes-Barre, Pennsylvania, Michigan and Colorado on a limited scale.

(4) **Prospective Cost-Based Approaches Incorporating Feature of Both (2) and (3)**—one of two approaches being tested by the Plan in Pittsburgh, Pennsylvania, as well as the "Maxi-Cap" system in operation in Rhode Island, entail in various procedural stages both the application of formulae and individual hospital budget negotiations.

(5) **Retrospective Costs with Financial Sanction (e.g. Caps) and/or Rewards**—A Prime example here is, Blue Cross and Blue Shield of Michigan's imposition some months ago of a transitional limitation program related to each hospital's annual increases in per diem costs.

Despite the level of effort to date, it is clear that more experimentation and better evaluations are needed on the positive and negative results of all the approaches tried. We would like to describe in some detail, however, the Rhode Island Maxi-Cap program, which represents a good example of the type of innovative and cooperative effort taking place. It has just been reported that as a result of that program, last year's percentage increase in total hospital expenditures in the state was at a level only slightly above 10 percent.

The Rhode Island Maxi-Cap program involves the combined participation and efforts of the Rhode Island Plan, the Budget Office of the State of R.I., the Hospital Association of R.I., and the Association's 16 member hospitals. The program objectives are multi-dimensioned—(1) to contain costs; (2) to relate growth in programs to statewide need; (3) to shift health resources and services away from the expensive inpatient care modality, where medically appropriate; (4) to provide incentives for improved management efficiency and improved productivity in individual hospitals; and (5) to insure that public access to quality care is not impaired. The program provisions encompass a variety of unique features, two primary ones being: (1) a statewide annual ceiling on aggregate gross operating expenses for all 16 participating hospitals, and (2) integration of health planning with reimbursement.

An official three-year analysis of the program will be conducted by Search, Inc. under contract with the Office of Research and Statistics of the Social Security Administration at the end of 1977 operations. There are, however, preliminary evaluations which indicate positive results, such as the 10 percent expenditure increase figure noted above. One finding is that through negotiations, objectivity has been brought to the payment process. Although in the first two years, negotiations were rather protected, improvements were realized in the 3rd year, wherein, the statewide "cap" was agreed upon in four negotiation sessions and one mediation session. Also, in fiscal year 1976-77 over 75 percent of all hospital budgets were resolved in only one negotiating session during a 60-day period.

Second: hospitals costs per admission have compared favorably with national and New England "averages", despite the heavier than average inflation forces facing Rhode Island hospitals due to their metropolitan locale, size, and complexity of medical education and clinical programs. Thus, the percentage average increase of costs per admission has over the past three years been declining more rapidly in Rhode Island (13.4 percent, 12.3 percent, 9.1 percent), compared to the national experience (17.2 percent, 15 percent, 15 percent) and average experience in New England (16.9 percent, 15 percent, 15 percent).

In combination with concurrent utilization review programs, Rhode Island hospitals have experienced a significant decrease in lengths of patient stays, which declined from 7.9 to 7.7 percent during the period 9/30/74-3/31/76. This is to be compared with an average rise from 8.3 to 8.7 percent in all Eastern states, and a constant 7.8 nationally during the same time period.

Also, by linking planning to the Rhode Island payment program, new and expanded medical programs have been controlled. Since 1974, the planning process in Rhode Island has reviewed requests for over \$6 million. Only \$3 million of projects were approved, which represents only 1.2 percent of total annual gross operating expenses of all hospitals in the state.

Other apparent by-products of the program include improved financial and overall hospital management—with resultant improved efficiencies and effectiveness in hospital operations, and significant reallocations of resources, mutually agreed upon by all parties through the budget negotiation process.

In reviewing the three-year experience of the Rhode Island Plan, it becomes apparent that the program has been an evolutionary one. This is evidenced by several revisions to the initial Maxi Cap program. Especially in the area of contingencies and volume corridors, it became apparent that modification of the program was required to insure timely administration. Fiscal year 1974-75 brought new malpractice problems whose impacts had to be recognized. Other revisions have been made such as modification of patient mix provisions, clarification of the use of "gains", and changes in the appeals process. All these changes have been made to effect continued improvement in the program and insure its viability for the future.

Drawing on lessons learned from the Rhode Island experience, the Blue Cross Association, under contract with SSA, is involved in the development over the next two years of a prospective payment approach which will link many of the features of a Rhode Island-type Maxicap program to a Health System Agency's Community Plan.

HEALTH PLANNING

Some references have already been made to Blue Cross Plan interest and involvement in health planning from the standpoint of linkage with prospective payment systems. It should also be stated that long before enactment of Section 1122

of Public Law 92-603, many Plans had already negotiated conditions for provider participation and reimbursement provisions in provider agreements which called for determinations of need for proposed capital projects based on sound health planning principles. Today, approximately 70 percent of all Plans have such health planning "conformance" clauses, and/or certificate of need programs have been enacted and are operational in those locales.

In addition, virtually all Plans are actively participating on the governing bodies or committees of state or local health planning agencies—as well as providing data or technical advice to the staffs of those agencies. A number of Plans, such as Group Hospitalization, Inc. serving the Washington, D.C. area, have become recognized leaders in the promotion of sound community health planning through their active involvement in HSA public hearing processes and in other public areas where critical health planning issues are being debated.

The "swing bed" concept, which Section 20 or S. 1470 promotes, is rooted in the voluntary efforts of the Blue Cross Plan in Utah and 18 of its participating health care institutions, begun in January, 1973. That program is now being funded under contract with ORS in SSA and involves many more eligible providers. Although official evaluation of the program will not be available until August, 1977 (the evaluation is being conducted by the University of Colorado), early indications are that the results have been favorable, offering an effective alternative to new long-term care facility construction.

In conjunction with SSA, other Blue Cross Plans are now participating in "swing bed" demonstrations. The Blue Cross Plan in Sioux City, Iowa is involved in such an experiment, which began August 1, 1976. Currently, there are 14 participating providers and 6 or 7 others are interested in joining the effort.

In addition, the Blue Cross Plan in Des Moines, Iowa commenced a swing-bed project with 24 providers in January, 1977, and the Texas Plan began on July 1, 1976 with 25 providers.

MEDICAL TECHNOLOGY

The Blue Cross organization, like many other entities in both the public and private sectors, has become increasingly concerned about the new technology being introduced into the health care delivery system. The rapid proliferation of computerized tomography (CT) scanning represents an important case in point.

Because of the major costs associated with the acquisition and on-going operation of CT scanning, combined with its apparent ready acceptance by many health care providers without clear evidence of its precise benefits and limitations, the Blue Cross Association requested and financed a study by the Institute of Medicine, National Academy of Sciences, to provide the Blue Cross organization and others with policy guidance concerning this new technology. We are currently evaluating the findings and recommendations of that recently completed study and have shared it with our Plans and a variety of other public and private entities for their review and use. We recognize that this report represents but a first step in resolving the issues surrounding the cost-effective introduction, placement, and use of not only CT scanning, but other existing medical technologies, and new ones we cannot yet foresee. At the very minimum, however, we hope that the study will help to stimulate broader public debate—toward identification of mechanisms at the national, state, or local levels to deal with this problem.

UTILIZATION REVIEW

Utilization review programs, consisting of such elements as retrospective review, concurrent review, and prospective review, represent another important tool for potentially controlling the costs and quality of health care.

Retrospective review, involving three levels of claims review, is the most common method used by Blue Cross Plans. The majority of Plans currently have physicians reviewing claims. The success of this type of review in achieving real cost containment results has been difficult to measure. The real success in retrospective review is where physician's practice patterns are altered over time so as to prevent the future rendering of medically unnecessary and inappropriate care. For instance, Blue Cross and Blue Shield of Kentucky have been involved for several years in a project of this sort. Through establishment of individual physician profiles, compared to those of appropriate peer groups, physicians are educated as to exceptional practice behaviors in order to positively modify their practice patterns.

Concurrent review is presently becoming a more popular utilization review method. Although experimental programs have not been fully evaluated, early results appear quite favorable. Seven Blue Cross Plans (in Cincinnati, Ohio; Connecticut; Washington, D.C.; Rockford, Illinois; Indiana; Michigan; and South Carolina) are jointly working in this regard with PSROs or medical care foundations. In addition, four Plans (Iowa; Maryland; Pittsburgh, Pennsylvania; and Wisconsin) have PSRO or foundation projects planned, nine Plans are in early stages of negotiations, and three Plans (Utah; Oregon; and Southern California) discontinued PSRO or foundation projects due to lack of favorable results or other considerations.

In total, fourteen Blue Cross Plans are involved in on-going or pilot programs in concurrent review directly with one or more hospitals. On-going Plan programs that cover all subscribers include: Blue Cross/Blue Shield of Delaware, Kansas Hospital Service Association, Blue Cross of Massachusetts, Blue Cross/Blue Shield of Michigan, Hospital Service Plan of New York, Blue Cross of Northeastern New York (Albany), Rochester Hospital Service Corporation, Blue Cross of Greater Philadelphia, and Blue Cross/Blue Shield of Rhode Island.

Blue Cross/Blue Shield of Michigan completed recently an evaluation of the first six months. Initial findings indicate:

The admissions per 1,000 members decreased by 2 percent in the first six months of 1976 as compared to the first six months of 1975.

The patient days per 1,000 members decreased by 5 percent.

The average length of stay decreased by 0.33 days (4.9 percent).

The estimated net savings from the first six months of the program are \$4,296,783.

The Blue Cross Association has developed two computer software systems to encourage and assist Plans and their participating institutions with the development and implementation of new or improved utilization review programs. The first system, referred to as Plan Utilization Review (PUR), is currently being used by 14 Blue Cross Plans for initial screening of claims to identify potential medically unnecessary or inappropriate services. The second system, the Joint Profile System (JPS), developed through the joint efforts of the Blue Cross and Blue Shield National Associations, is now operating in 15 Plans and two Plans are awaiting implementation. JPS has the capacity to produce a multitude of highly sophisticated computerized reports on utilization experience.

ALTERNATIVE DELIVERY SYSTEMS (HMOs)

For some time now, the Blue Cross Association and its member Plans have recognized the potential of the HMO concept as one alternative for containing health care costs. In a BCA policy statement in 1971, the support of HMO's was reaffirmed. The HMO Act of 1973 gave further credence to the concept.

The Blue Cross organization has long been active in starting and supporting HMO's. In 1970, three Blue Cross Plans were involved in five HMO programs with a membership of 700,000 subscribers. Today, there are 33 Plans involved with 63 operational Blue Cross Plan-related HMO's with a membership approaching one and one-half (1½) million. Blue Cross support of HMO's ranges from providing administrative services (e.g., out-of-area coverage and the processing of claims) to the full ownership and management of HMO's. Blue Cross has played a significant role in the creation of over twenty HMO's through management and/or marketing support.

Blue Cross now markets over 21 HMO's nationwide and such a market effort has often necessitated a complete reorganization and retraining of Plan marketing staff. The marketing of HMO's is a very different effort from selling traditional health insurance and is crucial to HMO growth. HMO marketing representatives must educated the public regarding health insurance and the medical delivery system which are molded together in an HMO, e.g., the advantages of preventive medicine, peer review, 24 hour access, health education and comprehensive health benefits. The HMO staff must make potential customers aware that there is something more to health insurance than paying bills and that a medical delivery system run as a prepaid group or individual practice association has incentives to keep subscribers out of the hospital and healthy.

In February of this year, the Civil Service Commission contacted the Blue Cross Association and Blue Shield Association regarding an application for a national network of Plan-related HMO's for inclusion in the Federal Employees Health Benefits Plans Program. An application has been submitted to CSC for

a network consisting of nineteen Plans with 22 related HMO's with a single rate and uniform benefits located across the country. Our expectation is that we will have a network contract with CSC in July of this year.

Under the HMO Act of 1973 and its regulations, thirty-one (31) HMO's have become federally qualified. Of these, eight (8) are Blue Cross Plan-related. One such program, the Genessee Valley Group Health Association in Rochester, New York has an enrollment exceeding 30,000 members and has demonstrated its cost-saving potential. Group Health was cited in a Council on Wage and Price Stability report for its low medical-surgical inpatient days in 1974 and a more recent study found that in 1975, Group Health members used 43 percent less medical-surgical inpatient days than nonmember area residents. This ability of HMO's to control hospital utilization along with their emphasis on preventive care is a major factor in the cost savings potential of HMO's. The Blue Cross organization will continue to support the growth of such programs.

While HMO's have demonstrated an ability to control hospital utilization reducing utilization rates by as much as 50 percent under traditional health insurance experience, HMO rates for more comprehensive benefits were often more expensive than traditional.

In the past two years, however, a new trend has emerged where HMO's with more comprehensive benefits have become less expensive. For the past two years the majority of HMO's in the federal offering have been less expensive than the full service benefit rate offered by traditional insurance programs. In 1976, 37 of 41 HMO's offered to federal employees had rates lower than the traditional service benefit rate (high option). In 1977, 31 of 46 HMO's had rates lower than the service benefit (high option rate). In California where the Kaiser Health Plan has some 19 percent of the health insurance market enrolled, their rates for the past several years have been 20-30 percent under traditional insurance rates for less comprehensive benefits. In Boston the Harvard Community Health Plan has a rate some 20 percent under the most widely held traditional insurance contract.

Blue Cross-associated HMO's are experiencing similar rate trends. In a study done for the large Detroit Blue Cross auto accounts, the majority of HMO's in auto account plant locations have rates at or below auto regular health insurance rates. Recent trends show that the HMO price for more comprehensive benefits is increasing at a slower rate than regular coverage.

The last six months has seen the culmination of many Blue Cross and Blue Shield Plans' investment in HMO's. Six Blue Cross and Blue Shield Plan-related HMO's are newly operational, one HMO achieved federal qualification status (joining seven other qualified Plan-related HMO's) and another is on the verge of obtaining qualification. Several other Plans are seeking qualification for their related HMO's and others are planning, developing and contracting with new programs.

INNOVATIVE HEALTH CARE BENEFITS

Four examples of significant innovative benefits offered by the Blue Cross organization are Home Health Care (HHC), Pre-Admission Testing (PAT), Ambulatory Surgery (AS) and pre-surgical consultation ("second opinion surgery") programs. All of these programs' primary objective is to reduce the need for or time period associated with the most expensive modality of care—hospital acute care.

Home Health Care encompasses a wide range of physician, professional, para-professional, technical, ancillary and related health and supportive services. Basically including all the services otherwise rendered to hospital inpatients, this benefit is appropriate for patients of all ages experiencing a wide range of medical conditions who are homebound for medical reasons.

If implemented and administered properly, this benefit can result in significant cost-savings, especially in the following areas: reducing hospital operating costs normally incurred in a hospital stay, and over the long term, reducing the future need for additional acute care beds. Statistics indicate that approximately 6 percent of hospital admissions could appropriately utilize home health services.

Plan involvement in Home Health Care began as early as the 1950's. Today fifty-four of the Blue Cross Plans now provide this benefit coverage to over 34 million subscribers. Plans in New York City, Philadelphia, Connecticut, Rhode Island, Massachusetts, and Chicago offer the most comprehensive Home Health Care benefits.

Stated simply, the objectives and advantages of Home Health Care are: to provide needed services to patients in their homes as a recognized and necessary component of a comprehensive health care delivery system; to provide for a lower cost yet medically appropriate alternative to institutional care; and to make use to the degree practical all resources available in the home recognizing that the family and home environment offer a substantially more therapeutic environment for patients.

Nevertheless, effective use of Home Health Care has been hampered by a general lack of acceptance and understanding of its nature and merits, a fragmented delivery system, limited capability to make the services available in certain rural or other locales, and a lack of adequate financing. However, limited evaluations of these benefits conducted by Blue Cross Plans indicate that Home Health Care can be a cost-effective alternative to institutional care.

Examples include the Philadelphia Plan's 1975 results which indicate that the average number of inpatient days saved through Home Health Care was about 12 days, yielding an average savings per case of \$875.

The Blue Cross Plan in Maryland estimated savings of \$250,000 in the first two years of operation of its program, with an average hospital stay reduction of 10 days.

The Plan in Rochester, New York has one of the nation's oldest and most comprehensive Home Health Care programs. Approximately 220 patients use this benefit daily, at an average daily cost of \$18, as opposed to \$116 in the hospital. During the 15 years of the program's existence, 10,000 patients benefited from Home Health Care and total hospital payments were reduced by \$1 million.

Pre-admission Testing (PAT) refers to the process of performing laboratory tests required of a scheduled inpatient admission on an outpatient basis prior to admission. Pre-admission Testing is most useful in the case of elective surgical admissions.

The multi-objectives of PAT are to: reduce length of stay per admission; prevent unnecessary admissions; improve quality of care through earlier availability of test results; reduce loss of work time to the patient; and help reduce over time the future need for acute care beds.

Blue Cross Plan involvement in Pre-admission Testing began in Philadelphia in the early 1960's and currently 57 Blue Cross Plans make this benefit available to 53 million subscribers.

Generally, Plans evaluations of the cost-effectiveness of Pre-admission Testing programs reveal a 1-2 day decrease in the length of stay of Pre-admission Testing patients compared to non-PAT patients.

As with other potential cost containment benefits, Pre-admission Testing's success requires the concerted efforts of subscribers, hospitals, and other involved parties to successfully implement and administer the program.

Ambulatory Surgery (AS), now offered by virtually all Blue Cross Plans, represents another potential cost-containing benefit with the primary objective of substituting procedures commonly performed in an inpatient setting. On a case-by-case basis outpatient surgery results in potential savings to the patient, e.g., one-to-three days stay in a hospital and the cost related thereto. Nearly all Plans have contractual relationships with hospital-based programs, and 21 Plans are currently contracting with free-standing ambulatory surgical facilities.

Second-opinion surgery is currently viewed by the Blue Cross organization as another innovation with cost containment and quality improvement potential. Blue Cross Plans are generally participating in such programs on an experimental basis, however, to determine whether those potentials are in fact realized.

Examples of Blue Cross Plans currently experimenting with second-opinion surgery programs are Blue Cross/Blue Shield of Greater New York, Pennsylvania Blue Shield, Blue Cross of Northeastern New York (Albany), and New Hampshire-Vermont Hospitalization Service.

Blue Cross/Blue Shield of Delaware, Health Care Services Corporation (Chicago), Blue Shield of Massachusetts, Blue Cross/Blue Shield of Michigan, Hospital Service Plan of New Jersey, Blue Cross/Blue Shield of Southwest Ohio, and Ohio Medical Indemnity are also planning to implement such programs this year on an experimental basis.

Evaluations of these programs are in its early phases. Currently, evaluation goals consist of measuring the effect of the program in reducing surgical utilization, the effect of the program on program users, and the effect on costs. None of the studies have attempted to assess the impact of the program on the total surgical utilization of the population covered; instead, they have focused solely on the sub-population of program users, which might unfortunately have the effect of inflating the results. At this point, none of the programs have been sufficiently evaluated to reach any preliminary conclusions.

In conclusion, the Blue Cross organization has been and continues to be actively involved in a variety of cost containment initiatives. More work is clearly needed in all of the areas described above, however, before as a nation we select any one approach or set of approaches for widespread adoption.

Senator TALMADGE. The subcommittee will now stand in adjournment, subject to the call of the Chair.

[Thereupon, at 11:25 a.m. the hearings in the above-entitled matter were adjourned.]

APPENDIX A

COMMUNICATIONS RECEIVED BY THE COMMITTEE EXPRESSING AN INTEREST IN THESE HEARINGS

FEDERAL TRADE COMMISSION,
Washington, D.C., June 13, 1977.

Re S. 1470—Medicare-Medicaid Administrative and Reimbursement Reform Act.

HON. HERMAN E. TALMADGE,
*Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate,
Washington, D.C.*

DEAR MR. CHAIRMAN: In response to the telephone request of Mr. Jay Constantine of the Subcommittee's staff, asking for comment on S. 1470, the Federal Trade Commission wishes to bring to the Subcommittee's attention the following points having to do with Section 15 of the bill.

The Commission is sympathetic with what we perceive to be the underlying concern of the bill—namely, a concern that unnecessary increases in Medicare and Medicaid costs should be prevented to the extent consistent with sound administration and the provision of adequate medical care. If enacted in its present form, however, Section 15 of the bill could exempt price-fixing activities from the antitrust laws, undermine certain Commission orders designed to prevent such activities, and entrench, rather than reform, inflationary conduct by physician associations. Accordingly, the Commission respectfully suggests that Section 15 be deleted from the bill or, at a minimum, that it be significantly modified.

Section 15 requires the Secretary of Health, Education and Welfare to propose a "procedural terminology" for physician services, to solicit comments on the terminology as well as proposed relative values for the various services, and to establish a "system of terminology, definitions, and their relative values. . . ." Similar "systems," commonly referred to as relative value scales (RVS's), have been developed by physician groups and have been in use for some time. A relative value scale is essentially a type of price list setting forth a compendium of services offered by physicians and a "rationalized" price structure in which the price of each service bears a consistent internal relationship to the price of each other service. Relative prices are stated in "units," and users typically convert the RVS into a price list by applying a conversion factor expressed as a number of dollars per unit. Thus, if several physicians adopt the same conversion factor, they will have identical price lists.

Relative value scales, especially those developed by physician groups, have several anticompetitive tendencies:

1. To the extent that relative value scales are adopted by physicians, price structures are rigidified, since the ratio between prices for various services will, for users, tend to be the same. Deviations from an RVS may of course be made—and undoubtedly are made in many instances—but use of RVS's nonetheless points physicians away from totally independent fee-setting and toward relative price stabilization.

2. Moreover, the existence of an RVS facilitates "hard-core" collusive price-fixing. Physicians who want to fix actual as well as relative prices need merely agree on a conversion factor. This avoids the problems involved in negotiating a separate agreed-upon price for each separate procedure.

3. The definition of a professional's services may itself be a method of competition, for some competitors may offer more for a given price than others. Standardization of nomenclature by physician groups thus can stifle variety, innovation, and the incentive to give patients "more for their money." Additionally, the more a nomenclature fragments services, the greater the tendency may be for physicians to bill for a purportedly larger number of services or for

the procedure with the highest relative price. For example, many relative scales have distinguished among office visits of various lengths; and given a choice, for example, between "brief," "intermediate," and "extended" office visits, physicians may be expected in many instances to resolve close questions in favor of the longer visit bearing the higher relative price. There is evidence that in recent years there has been a general increase in the fragmentation in RVS's which have been developed by physician associations—a development which many third-party payors consider to have had an inflationary effect.

4. In addition, the development or modification of an RVS by physicians may be specifically intended to raise the relative price of particular procedures. Where this occurs, it is likely that actual prices will in fact be increased. For example, a few years ago the American College of Obstetricians and Gynecologists increased the relative price of full-term pregnancy care in its RVS to equal the relative price of a hysterectomy. Even with no increase in conversion factors, physicians using this RVS would begin charging more for pregnancy care.

Obviously, an RVS can be a convenience for both physicians and third-party payors. The latter, such as government agencies and commercial insurance companies, may create RVS's from their own resources and for their own use, and in so doing they are likely to have foremost in mind the need to minimize the costs of their programs. Even in such a case, depending on the significance of the particular RVS involved, its dissemination could lead to its being used to some extent as a pricing "guide" by physicians and hence to some price stabilization. Nevertheless, it would not be unreasonable to conclude that, on balance, the independent RVS activities of third-party payors produce a consumer benefit. When physician groups engage in RVS activities, however, the balance is likely to shift against consumers since sellers are typically not so interested in keeping prices down. Ordinarily, an RVS that is created by physicians is designed to rationalize the market, and its dissemination to and adoption by physicians tends to deprive consumers of the variety and enforcement efficiency of competition. Thus the creation and dissemination of relative value scales by private groups of physicians may be regarded as inherently anticompetitive.

In a number of instances this reasoning has resulted in complaints being issued or filed. The Commission has issued complaints against the American College of Radiology, the American College of Obstetricians and Gynecologists, and the American Academy of Orthopaedic Surgeons, and has proposed a complaint against the Minnesota State Medical Society, each complaint alleging that the creation and dissemination of relative value scales constitute unfair methods of competition and unfair acts and practices in violation of section 5 of the Federal Trade Commission Act. In addition, the Department of Justice has filed complaints against the American College of Anesthesiologists and the Illinois Podiatry Society. The Commission's first three cases were settled by consent agreements, as a result of which final orders were issued prohibiting the respondents from developing relative value scales and engaging in related activities; and a proposed consent order is pending in the Minnesota case. The Justice Department cases are being litigated.¹ (CLERK'S NOTE.—The cases referred to were made a part of the official files of the Committee.)

As we have noted, section 15 of S. 1470 requires the development of a relative value scale for Medicare-Medicaid use. We certainly endorse the objective of cost containment which the bill is intended to further. However, we question whether section 15 contributes appropriately to that objective.

We understand that the bill does not alter the current basis for making reimbursement determinations, under which fees are reimbursed if they are within the prevailing range of fees for the procedure or operation in question. In making such determinations, however, a relative value scale is only one of the tools that may be used; and a relative value scale approach may have anticompetitive consequences which would outweigh its benefits, especially in light of the massive impact of the Medicare and Medicaid programs in the health service market. For example, an RVS adopted by HEW could have substantial price-stabilizing

¹ Copies of the Commission's complaints and consent orders are enclosed herewith. All of these cases—those filed by the Department of Justice as well as the four Commission matters—have focused entirely on the creation and dissemination of RVS's by physician groups. The creation or use of an RVS by an independent third party payor, such as Medicare, has not been involved in the Commission's challenges to the role of competitors in developing RVS's.

effects through physician adoption of the scale. Further, a nationwide RVS could well impose price relationships among services inappropriate to the relative demand and supply balances for those services in particular parts of the country. Thus, on balance, it is difficult to perceive the justification for publishing an RVS, at least so long as the reimbursement system is not changed at the same time to an RVS or "fee schedule" system. Since it appears that section 11 of this bill retains the traditional criteria for determining reimbursement, there is a strong basis for concluding that section 15 should be deleted from the bill entirely.

In any event, if an RVS approach nevertheless is to be used, we believe that its anticompetitive effects can and should be limited. As we have indicated, the negative effects of relative value scales are accentuated when the scales are developed by physician groups. Since we assume that HEW has sufficient staff expertise to develop its own RVS internally, it is unclear to us why the bill should involve RVS activity by physician associations. Thus we strongly recommend that if section 15 is to remain in the bill, it should be modified to restrict the development of relative values to government agencies. While it is appropriate to allow individual health care providers an opportunity to comment on any government-proposed reimbursement schedule, sound public policy would surely dictate that this opportunity be afforded under the established procedures of the APA, 5 USC, § 553.

In addition, we have three specific concerns regarding subsections of section 15 of the bill as it is currently drafted:

1. Initially, we wish to express our view that the provisions of section 15(c), which in effect overturn certain Commission consent orders, are unnecessary and inappropriate. The consent orders in question, which we have cited above, prohibit certain physician groups from (1) developing or disseminating relative value scales, and (2) submitting to third parties information or testimony bearing on fees unless the information is limited to objective, historical data. Section 15(c) would permit the groups in question to submit relative value scales to HEW regardless of the orders.

We assume, without examining the question, that properly issued administrative orders may, as a constitutional matter, be overridden legislatively in this fashion. We want to emphasize, however, that the physician groups in question voluntarily agreed to the terms of the orders. Even assuming that it is desirable to invite and consider the views of medical associations with respect to the RVS system which the bill establishes, there exists more than sufficient medical expertise available to HEW even if the handful of groups who have signed consent orders remain bound by the terms of those orders. We can see no persuasive justification for permitting organizations which have voluntarily bound themselves to certain restrictions through appropriate and established FTC procedures and orders to be allowed to evade the obligations they have thus undertaken.

2. We note that section 15(c) contains a proviso evidently designed to mitigate the anticompetitive tendencies which might flow from allowing the groups in question to engage in RVS activities despite the existence of consent orders. The proviso states that no relative value scale which any such group proposes to the Secretary of HEW shall be "disclosed to anyone other than those persons actually preparing it or their counsel until it is made public by the Secretary." This is a desirable caveat, since otherwise the groups in question could, for instance, disseminate to their members, the RVS's which are submitted to the Secretary, with the likely result that such RVS's would be adopted and used by a significant number of physicians even though they had an inflationary impact. We have two concerns with respect to this point, however.

- (a) It is not clear whether the Secretary is to publish only a system which he finally adopts or whether he may "make public" each and every RVS suggested to him. If the latter construction were adopted and implemented by the Secretary, the anticompetitive tendencies which we described at the outset of this letter might well be encouraged, since the members of the physician groups in question would be aware of the RVS's "endorsed" by their organizations. Hence we suggest that the proviso be clarified to make clear that only an RVS which the Secretary proposes for adoption or approves should be made public.

- (b) More broadly, we are concerned because the non-disclosure proviso applies only to the groups covered by section 15(c)—i.e., those under consent orders.

All other physician groups are permitted by section 15(b) to submit proposed RVS's to the Secretary, but no restriction on disclosure appears in that subsection. Thus by negative implication it might be concluded that all physician groups except those under consent order may disseminate to their members or otherwise publish the relative value scales which they have proposed to the Secretary. In light of the principle that exemptions from the antitrust laws are not lightly inferred,² such a conclusion—which would in effect constitute an antitrust exemption for almost all relative value scale activity by the medical profession—would in our view not be soundly based. But the matter should not be left to the uncertainties of litigation, especially since adoption of such a construction could, as we have indicated, have major anticompetitive effects. We suggest, therefore, that if the basic approach taken by section 15 is to be retained, the nondisclosure proviso of section 15(c) be enlarged so that it would apply to any group submitting an RVS to the Secretary.

3. Finally, we wish to point out that section 15(e) may be construed to legitimize anticompetitive conduct in another major respect. It provides that once a relative value scale is approved by the Secretary, it "may subsequently be used by any organization for purposes other than those of this Act." "Organization" is a term broad enough to cover not only commercial insurance companies and other third-party payors who may have a legitimate reason for using relative value scales but also medical associations and other physician groups which might recommend that their members use a scale to fix prices. Similarly, the term "purpose" is broad enough to include activities which would violate the antitrust laws as well as legitimate activities. Taken literally, therefore, this provision could shield from the antitrust laws the type of collusive conduct which, for the reasons noted above, has been challenged by the Commission and the Justice Department. Here too the courts might be reluctant to infer an antitrust exemption and might limit the permission to use RVS's "for purposes other than those of this Act" to purposes not prohibited by the antitrust laws. But a contrary outcome again is not totally inconceivable, and the question should not be left to litigation. The permissive language should be eliminated—or, at a minimum, modified to make it clear that no exemption from antitrust coverage is intended.

In summary, given the substantial anticompetitive effects of RVS's and the invitation to collusion that could accompany enactment of section 15, it may well be appropriate to consider deleting this section from the bill. At the very least, however, it should be substantially modified as suggested above in order to avoid undermining established Commission consent order procedures and opening the door to possible anticompetitive activity by physician groups.

By direction of the Commission.

MICHAEL PERTSCHUK,
Chairman.

STATEMENT OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman, I am David C. Crowley, Executive Vice President of the American Association of Homes for the Aging. The American Association of Homes for the Aging represents the not-for-profit providers of institutional services to older Americans and their residents. Among our members are facilities which participate in the Title XVIII (Medicare) program as skilled nursing facilities and in the Title XIX (Medicaid) programs as skilled nursing facilities and intermediate care facilities.

We are pleased to have this opportunity to comment on S 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act. We commend this committee for its continuing efforts to improve the performance of these two

²E.g., *FMC v. Seatrail Lines, Inc.*, 411 U.S. 726 (1973). In *Otter Tail Power Co. v. United States*, 410 U.S. 366 (1973), the Supreme Court reiterated its historic reluctance to find antitrust exemptions in statutory language of a general nature: "When . . . relationships are governed in the first instance by business judgment and not by regulatory coercion, courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Id.* at 374. In a frequently quoted earlier holding, it stated that rule this way: "[R]epeals of the antitrust laws by implication from a regulatory statute are strongly disfavored, and have only been found in cases of clear repugnancy between the antitrust and regulatory provisions." *United States v. Philadelphia National Bank*, 374 U.S. 321, 350-51 (1963).

programs, and our association joins with the many public interest groups which have come before the committee urging expeditious consideration of these reform amendments.

To facilitate review of our comments, we set forth our viewpoint with respect to S. 1470 on a section-by-section basis, offering additional issues for possible consideration by the committee within this reform package as the final points of our testimony. However, prior to turning to the specific amendments, we wish to reiterate several themes which we have raised with the committee in previous statements during past Congresses.

First, we cannot over-emphasize that further Committee consideration must be given to improving the responsiveness of the Medicare benefit package to the needs of the elderly; to standardizing the eligibility and benefit criteria of the Medicaid program; and to developing a comprehensive program addressing the delivery of long term care services to the elderly. The two programs which this Committee have under review fail to cover adequately the costs of long term care.

Medicare, the major federal health program enacted to assist the elderly, is so fraught with durational limitations, entitlement preconditions, and service constraints that assistance to individuals needing long term care is severely restricted. Essentially, Medicare covers short-stay, convalescent skilled nursing services following hospitalization. Medicaid, the federal-state shared program providing health services for the indigent, pays for a limited range of long term care services which are narrowly defined as "medically necessary." Program standards, including rules for utilization review, physician approval and staffing, have tended to reinforce the view that long term care services are medical services. Management of the program is vested in the states; therefore, eligibility and benefit criteria vary greatly by jurisdiction. Both programs limit reimbursement to long term nursing and medical services. They ignore the fact that social components of care are necessary to maintain an individual's active functioning. The medical emphasis of Medicare and Medicaid often impedes the provision of social supports necessary to enhance the quality of life within the institutional setting. We ask this Committee to assume the leadership in overcoming the fundamental assumption which pervades present public policy; i.e., that older people are either generally well and primarily in need of income supports, or they are generally sick and primarily in need of intense medical service. We implore your attention to these issues of benefit coverage and program review.

Second, while our association is generally supportive of the amendments contained in S. 1470, we temper our enthusiasm with a caution that Congress must be continually vigilant that its actions do not impact detrimentally upon the older person in whose interest we are acting. Actions which reinforce the medical emphasis of the Medicare and Medicaid programs may restrict the eligibility of the older person to receive the benefit. Directions which confuse the policy instruments of Medicare and Medicaid to focus solely on the service needs of the acute, episodic patient population impact negatively upon the chronically ill, long term patient.

One cannot over-emphasize that long term care facilities are reimbursed under the law for the provision of services to two differing patient populations, and that administrative reforms should account for the differing needs. In pursuing policy objectives to strengthen the efficiencies of the provider of services, we must be mindful not only of the potential trade-offs which might occur between cost containment and quality, but also the external factors of differing products: i.e., differing patient mix, differing intensities of services, etc. Medicare and Medicaid long term care policy objectives must not be confused.

Third, we ask the committee to seriously review the ramifications of general policy decisions on the specific components of the market being affected. One of the most striking conclusions of the Thomas study of Nursing Home Policy in New York State exclaimed:

"From the 1930's on through the early 1960's nursing home type institutions were more strongly affected by public policy not directed at them than by that designed to influence them. Policy affecting the facilities was much like the forces shaping a whirlpool. An abundance of tangential influences give the whirlpool form, but the vortex is a vacuum."¹

¹ Thomas, William. "Nursing Home Policy in New York State" (Cornell University Press, Ithaca, New York) 1969, p. 248.

While the advent of Medicare and Medicaid has heightened the recognition of nursing home issues, there is a continuing lacuna of policy debate on the specific impact of reimbursement and administrative decisions upon long term care services. A clear danger lies in the lack of knowledge and the habitual lack of attention to the conditions and the interaction of conditions which are peculiar to the aged and which create long term care needs and, in the tendency to fill this vacuum with the simple transference of methods, rules and norms from the familiar grounds of hospital practice.

Turning to the specific provisions of S. 1470, we offer the following comments:

Section 2: Criteria for Determining Reasonable Cost of Hospital Services

Our association notes that the provision of this section pertains only to hospitals. We are pleased that the sponsors of this legislation recognized the differing economic circumstances of the hospital sector and the long term care sector. As mentioned above, the failure to distinguish between these services has often had the effect of requiring long term care facilities to respond to directives which had limited application to their circumstances, and which in turn, had the resultant effect of reinforcing the "mini-hospital" view of extended care.

Without belaboring the issue—but recognizing that some members of the Congress have made reference to nursing homes during hearings on S. 1391—we urge careful consideration of the facts presented in a recent Urban Institute study on Medicaid Cost Containment Policy, Long Term Care Reimbursement, which points out:

"* * * Since hospital, as opposed to nursing home, cost inflation has received such extensive investigation, perceptions of problems and solutions developed there may be shifted without thinking and possibly without justification to the nursing home area. Rapid hospital cost inflation has been extensively documented and repeatedly attributed largely to (1) the insulation of consumers from hospital costs by the prevalence of third-party payments and (2) the use of "reasonable costs" arrangements to determine third-party levels. Nursing home cost inflation has not received the same documentation nor has it been subject to similar analysis. Nursing home cost dynamics, however, could not receive the same explanation as hospital cost dynamics because of differences in prevailing reimbursement arrangements."²

With respect to reimbursement for long term care, we trust this Committee will continue its efforts to have Section 249 of Public Law 92-603, which provides for reimbursement on a reasonable cost related basis for skilled nursing and intermediate care facilities implemented. While the statute clearly requires that states implement this payment system by July 1, 1976, the previous Secretary of Health, Education, and Welfare thwarted the will of Congress by delaying the publication of regulations until July 1, 1976, and the timetable for state action to January 1, 1978. Certainly, this Committee should make sure that states are not taking advantage of the delayed implementation to continue inadequate reimbursement for services in SNFs and ICFs. The Secretary of Health, Education, and Welfare should be asked to bring the Department into compliance with the statute immediately.

Sections 3 and 20: Closings, Conversions and Hospital Providers of Long Term Care

While our association is supportive of the provisions set forth in S. 1470 for promoting the utilization of surplus hospital capacity for the delivery of long term care services, we caution members that conversions (1) will account for only a small fraction of the supply of facilities necessary to meet the growing demand for long term care institutional services, and (2) provide facilities that will require extensive renovation if they are to attend to the needs of the long term care patient/resident. We express these cautions in hopes of dampening the viewpoint that the panacea to the so-called "glut of hospital beds" is to transform them into nursing home beds.

Section 20 appears to be a realistic approach to the conversion process, i.e., providing for an initiation of the program in those areas where the most severe shortages of long term care beds persist, and ensuring a parity in the reimbursement structure. In responding to the Section 223 proposed cost limits last October, our association raised the question of providing for special consideration of

² Pollack, William, *Medicaid Cost Containment Policy: Long Term Care Reimbursement* (Urban Institute, Washington, D.C.) 1976, p. 7.

costs associated with patient mix, geographic location, size and relationship with hospitals. We suggested that the data points to several factors which influence the costs of hospital affiliated long term care facilities: (1) more acute illness, (2) higher Medicare reimbursed patient mix, and (3) higher costs due to patient turnover by the hospital based skilled nursing facility. In establishing the parity for reimbursement between the converted hospital beds and the free-standing neighboring facilities, the Committee might wish to review these influences. At a minimum, waiver provisions based on these factors should be allowed for facilities which can show adverse cost consequences of the limits imposed by Section 20 as an incentive for the demonstration project conversions.

Returning to our basic point with respect to conversion, the Committee must be conscious that the rising demand for institutional long term care services is most evident with respect to congregate care, residential living with personal care services, and intermediate care services. While the services offered in these institutional settings is as important as the medical care rendered in skilled nursing facilities, the primary thrust is to provide protective shelter with personal and environmental assistance to an ambulatory, long-stay population. Certainly, the mere physical structure of a hospital setting inhibits the flexibility in a program necessary to meet these needs of patients/residents.

The issue of hospital conversion to long term care facilities increases the necessity for the Congress to seriously address the problem of whether the benefit is linked to the facility in which a recipient is placed, or to the actual care rendered to the patient. This issue has been raised with respect to the definition of a "spell-of-illness" and with respect to the reimbursement for durable medical equipment under Section 1861(s). In recent court decisions (*Kathryn Hasek v. Mathews* and *William Perry Eisman v. Mathews*), the courts have ruled with respect to the definition of "spell-of-illness" that a break occurs if the recipient is not receiving a skilled service irrespective of residence within a facility that is dual certified. We applaud these decisions, and encourage the Congress to ask the Department to clarify present regulations to conform with these court rules. Furthermore, we ask the Congress to clarify the provision of 1861(s) (6) to refine the prohibition clause from blocking coverage for an individual who resides in a facility to restricting coverage for an individual who is receiving benefits under Part A of the program and is residing in a facility that meets the requirements of Section 1861(e) (1) or (j) (1).

Section 4: Federal Participation in Hospital Capital Expenditures

While we concur with the intent of this section to mesh the provisions of the National Health Planning and Resources Development Act of 1974 with the capital expenditure provisions of the Social Security Act, as amended, there appears to have been several technical changes in Section 1122 that might have serious ramifications for providers of long term care services.

The major change relates to the proposed rewrite of Section 1122(g). Lines 9-12, page 23 of S 1470 propose a major change from the current statute which reads "* * * and which (1) exceeds \$100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made * * *."

The proposed change could be interpreted as requiring a Section 1122 review for any bed changes and/or for any changes of the mix of beds in which a higher cost usage (level of care?) is made. Besides being an administratively cumbersome requirement to force a review for all bed capacity—one which has been debated and compromised within the regulations for Public Law 93-641 providing for an operational definition of the term "substantial" bed changes—it becomes virtually impossible with respect to level of care changes in dual certified SNF/ICF situations. As the preamble to the final regulations implementing Public Law 93-641 certificate of need requirement points out: "* * * one commentator expressed concern that since bed use may change daily from one category to another (e.g., "skilled nursing facility" to "intermediate care facility") it would be impossible for a certificate of need program to regulate these constant variations. Daily bed fluctuation clearly need not be subject to certificate of need review, because States are required by the Federal regulations to review only substantial bed changes * * *."³

³ Department of Health, Education and Welfare, Public Health Service, "Health Planning, Capital Expenditure Review, Certificate of Need, and Review of New Institutional Health Services Rules and Regulations," as cited in Federal Register, vol. 42, No. 14, Jan. 21, 1977, p. 4008.

Certainly, if the Committee's purpose is to improve the flexibility of our health system to meet the needs of the recipient, then it must not impose a bureaucratic review process that is so rigid as to prevent the rendering of appropriate care. From the perspective of the provider attempting to deliver quality care, there can be diminishing returns from such over-regulation. Time spent meeting paper requirements is time taken away from the resident.

Section 10: Physicians' Assignments

Our association views the proposed changes to Section 1868 as constructive, and we hope they will be instrumental in attracting more physicians to accept assignment. We see particular merit in the provisions for simplified billing. It would be helpful for residents of institutional facilities, such as homes for the aging, personal care homes and nursing facilities, if the Committee clarified the incentives for Part B simplified billing. While we have only encountered occasional problems, it appears that in many instances medical directors, as physician consultants, bill for the individual services rendered to patients. However, in those instances where a facility hires the physician as a fulltime member of the staff and/or provides as an incentive for the physician's involvement within a facility the services of centralized billing, there have been conflicting interpretations as to the reimbursement procedures under Part B. The complications are forced through the continuing debate of interpretation to clauses such as the one offered on lines 6 and 7 of page 27, "or are performed outside the office of the participating physician." If the physician maintains an office and also has an office as a medical director of a nursing home, is she eligible for administrative cost-saving allowances?

We suggest the Committee may wish to consider specific report language and/or statutory language assuring the benefits of physician assignment to residents of extended care facilities.

Section 12: Hospital Associated Physicians

We ask the Committee to review carefully the implications of Section 12(b) with respect to the coverage of medical and other health services, i.e., amending Section 1861(s). As written, the limitation would require Secretary approval of 2(A) and (3) services "if furnished to inpatients of a provider of services * * *." Does this mean that services rendered to a patient of a Part A skilled nursing facility would have to be reviewed? While it appears as if the intent of these limitations is to restrict over-utilization of certain nonessential hospital services, one could extend the limiting clauses as restricting reimbursement for services is skilled nursing and intermediate care facilities.

Section 21: Reimbursement Rates under Medicaid for SNFs and ICFs

Section 21 raises one of several important issues which surround the implementation of Section 249 of Public Law 92-603 requiring reimbursement on a reasonable cost related basis for skilled nursing and intermediate care facilities participating in the Medicaid program. While our association strongly urges the Committee to clarify its mandate to the Department of Health, Education and Welfare with respect to the profit issue, we further solicit Committee direction to the Department to move toward compliance with the statutory requirements of the 1972 law.

As written, Section 21 leaves unclear the important distinction between profit in the economic sense and profit in the accounting sense. This is a crucial distinction with respect to the allowance for surpluses to not-for-profit providers of services. In the economic sense, a profit includes surpluses to facilities in which the community (as opposed to the corporate investors) has invested, and given the requirement for equity, the profit (surplus) is a calculated return to all providers to compensate for the costs associated with the alternate investments that could have been made (economic opportunity costs).

In an accounting sense, a profit can only be rendered to that class of facilities which is proprietary, inasmuch as the other classes of providers—non-profit and governmental—are by definition prohibited from accumulating a profit. We urge the Committee to slightly amend Section 21, line 20, page 46, to read "a reasonable profit or surplus for the facility * * *"

From the perspective of the not-for-profit providers of services, the issues associated with profit and incentives for community investment in quality services have not been sufficiently reviewed. While this series of amendments may not be the most appropriate legislative point for consideration of the motivations of

the participating providers, the implications of allowing Section 249 to be implemented without provision for surplus are major. A failure to encourage community investment in services at this point in time may indeed force the not-for-profit sector out of the Medicare and Medicaid programs. With limited opportunities to accumulate needed investments for capital replacement and expansion, or to recoup costs associated with present investment opportunities, the not-for-profit sector is disadvantaged in the market to meet projected supply needs for institutional services (growth). We appear to be replicating the lacuna of conscious decisionmaking which led Thomas to write:

"One of the major problems for public policy that this history reveals is that the community found itself putting its resources into a set of facilities that was not its choice. It would appear that if public money is spent there is a concomitant responsibility that it be well spent, and that this requires at least some examination of alternative means by which it might be spent and the selection of that means that appears most reasonably calculated to achieve the intended consequence.

"However, there had been no decision by the community or its representatives in 1930 or 1935 to use proprietary nursing homes. The community and its representatives had not recognized that there was a need to be met, had made no provision to meet it, and therefore had not seized their opportunity to decide what instruments they would use to perform the indispensable function of caring for the aged sick."⁴

We are again at the crossroads of selecting the pattern of services and the delivery system that will be required for the remainder of this century and the first stages of the next. Demand for long term care institutional services and for related long term care services within the community is rising. One need only review in a casual manner the recent Budget Issue studies of the Congressional Budget Office [particularly the papers on Catastrophic Health Insurance (January, 1977), and Long Term Care for the Elderly and Disabled (February, 1977)] to recognize that the supply aspects of the delivery system need to be stimulated. The Committee must consider whether the present implementation of Section 249 provides sufficient stimulus for investment, and if the stimulated investment is in the best interest of the public.

Implicit in the Department's regulations for implementing Section 249 is a bias against the not-for-profit sector. Without justification, the preamble to the July 1, 1976, rules prejudices the inclusion of growth allowances as a valid form of reimbursement by the states, and without explanation read into Section 1902(a) (13) (E) of the law a prohibition that is neither mentioned in the statute nor in the Committee supporting material. The draft guidelines which have been prepared by the Department specifically state that "in no case may the allowance include a factor as a return on equity for nonprofit providers," citing the preamble to the regulations, page 27303, third column, which reads in part:

"States may include as an allowable cost whatever return on owner's net equity they conclude is necessary to avoid withdrawal of capital and to attract additional capital needed for expansion. This return on net equity of proprietary providers is the only item of profit that may be included as an item of allowance costs. States may conclude that such a profit factor is necessary to avoid withdrawal of capital and to attract additional capital needed for expansion. On the other hand, such a profit factor would not be an appropriate element in the calculation of the reimbursement rate for nonprofit and government providers."⁵

If the states are to be allowed flexibility in developing their delivery system, and be allowed the option to include a profit on the dubious criteria of invested equity for proprietary investors, why force the not-for-profit sector to look elsewhere for investment capital?

Even the proprietary providers recognize the precarious dilemma which confronts not-for-profit deliverers of services. In a recent report commissioned by the national organizations representing the proprietary sector of the long term care field, the accounting firm of Clifton, Gunderson and Co. pointed out:

"The capital that must be attracted to the industry comes from three sources: Federal, state, or local government: social, religious, or charitable organizations; private individuals and organizations.

⁴ Thomas, op. cit., p. 252.

⁵ Department of Health, Education, and Welfare, Social and Rehabilitation Service "Reimbursement on A Reasonable Cost-Related Basis for Skilled Nursing and Intermediate Care Facility Services Rules and Regulations," as cited in Federal Register, vol. 41, No. 128, July 1, 1976, p. 27303.

Since none of the three sources has infinite funds to finance all possible projects, the nursing home industry must compete for funds with the other investment opportunities. Because the investors (whether government or individual) have alternative opportunities for investment, the payment received for invested capital must be considered a cost, for as capital is used, it must be replaced. If capital is not replaced, then the project it originally finances will be liquidated over a period of time."⁶

While the principal avenues for recouping the costs of present capital investment are allowable costs for providers, either as interest charges and/or through depreciation allowances, we call to the Committee's attention the preamble language excluding profit (surplus) for the attraction of additional capital for the not-for-profit provider. Please be mindful of the Battelle Memorial Institute study on *Allowances for Owner/Operator Contributions in a Cost Related Prospective Payment for Services System for Nursing Home Care* which declares:

"... As discussed above, the allowance provided to the owner/operator for capital costs must be sufficient to maintain the stock of capital in the industry. But, in addition, in an industry which is expanding, the attraction of additional capital is required. This implies a need for "economic profit" or a return on owner/operator capital somewhat higher than the amount sufficient to maintain the present stock of capital resources in the industry."⁷

It is of particular importance that in an exchange of correspondence with this Committee last fall, a representative of the largest trade association of proprietary nursing homes alluded to the difficult situation confronting the not-for-profit sector:

"... An additional and very important consequence of the July 1 regulations is the prohibition of the payment of any bonus or growth allowance to nursing homes operated by churches and other nonprofit sponsors. I do not believe the Congress intended to force these providers to finance capital improvements and future expansion solely out of private subsidies or through increased charges to private payment patients. The earning of an amount after costs are defrayed is as important in an economic sense to nonprofit institutions as it is to those which are operated for profit."⁸

Two arguments are commonly used to condone the disincentives to community investments in quality care: (1) not-for-profit providers can tap massive reserves of charitable dollars, and (2) the not-for-profit sector consumes all monies in present services. Both positions are debased of fact.

With respect to the massive reserves of charitable dollars, we have already pointed out the economic opportunity costs which are associated with the community investment are similar to those associated with private investment. However, beyond the theory, in practice, inflation has had a major impact of drying up community resources. Deterioration of religious, ethnic and family ties—all well explored in current sociological literature—curtail the flow of funding sources. While these factors led to an increased government investment in nonprofit long term care facilities through the Hill-Burton program and during the past two decades, that program has been revised and reduced.

With respect to the implementation of the Section 249 provisions, our office is most concerned with the trend of state plans to place undue restrictions on the use of charitable contributions to nonprofit facilities, which further exacerbates the problem. For example, under the Missouri State Plan which was filed with the Regional Office of HEW, facilities are required to include "investment income, grants, taxes, gifts and income designated by the donor for specific operating expenses" within gross revenues for purpose of rate setting. In the practical application of this computation, the gifts that have been solicited and received by nonprofit homes (in accordance with the February 19, 1976, ruling by the DHEW Acting Assistant General Counsel) reduce the per diem costs to the state by the amount of community support, thus virtually eliminating the

⁶ Clifton Gunderson & Co., *Rate Setting Forms and Instructions for Long Term Care Facilities Utilizing a Cost Related Payment System* (under contract of Illinois Health Care Association, American Health Care Association and National Council of Health Care Services) March 1, 1976, p. III 2-3.

⁷ Battelle Memorial Institute, *Allowances for Owner/Operator Contributions in a Cost Related Prospective Payment for Services System for Nursing Home Care* (under contract of the American Health Care Association) 1975, p. 8.

⁸ Letter of Mr. Bruce D. Thevenot, Director, Government Services Division, American Health Care Association to Senator Herman E. Talmadge, Chairman, Subcommittee on Health, Senate Finance Committee, September 14, 1976.

incentive for seeking broad base public support for the services to the elderly. More importantly, because the state plan disallows any consideration for return on invested capital for nonprofit homes, the actual effect of the limitation on community support is to remove the primary source of investment capital for the not-for-profit sector. Under these rules, not only would a home be penalized for attempting to develop a sense of community involvement in the care offered to older persons, the not-for-profit facility would be prohibited from accumulating necessary capital funding for purposes of equipment replacement and facility expansion. We cannot believe that Congress intended the exogenous determination of levels of philanthropic assistance to be the controlling influence of the acceptable growth of the not-for-profit provider, and we certainly cannot understand why, if this factor was to be the only source of capital funding, states are allowed to restrict its accumulation.

The myth of unchecked consumption is equally devoid of substance. Reimbursement systems are developed to fulfill several objectives. The two most prominent reimbursement objectives are cost control and the provision of quality services. While it is evident in both theory and in practice that not-for-profit providers proudly accent quality of service and responsiveness to patient/resident needs, such an accent is not and cannot be achieved without attention to the principles of cost containment. The recent Urban Institute study, cited above, points out the following with respect to the trade-offs:

"For proprietary facilities the incentives of a reimbursement scheme consist of the behavior it induces providers to follow in their efforts to maximize profits. Non-profit facilities obviously do not have the simple objective of maximizing the excess of (sales) revenue over costs. Indeed, the contributions which many non-profit organizations solicit are sought in order to permit a deficit of costs relative to sales revenues. The incentive effects of facility-independent (or other) reimbursement arrangements for non-profit facilities, consequently, are not to be found by tracing the implications of profit maximization. Nonetheless, on the assumption that they seek to survive and to maximize quality (given quality and other constraints), non-profit providers are subject to incentives from facility-independent reimbursements. Specifically, the independence of reimbursement from costs and the exogenous determination of levels of philanthropic subsidy together force non-profit facilities to produce efficiently—that is the only route to high quality with (reimbursement plus subsidy) resources and quality held constant.

"Thus, facility independent reimbursements encourage nonprofit as well as profit providers to be efficient. The only difference is that the non-profit facility is less likely than the proprietary facility to use this induced efficiency to "buy" lowered total unit costs and an enlarged surplus. Rather, it is likely to use it to "buy" higher quality. The efficiency which facility-independent reimbursement induces in non-profit providers is therefore likely to generate a higher ratio of quality to cost than would otherwise occur."⁹

Given the continued Congressional initiatives to improve the quality of services within nursing homes, we cannot conceive that attention to cost containment was the single criteria motivating the enactment of Section 249.

The position which our association took with respect to the encouragement of states to elect the option of class groupings as the criteria for reasonable cost-related reimbursement, as communicated to the Committee Chairman in a letter of July 8, 1976, emanates from this same trade-off between quality and cost containment. As the Battelle Memorial Institute study indicates, the differences in long-term care average costs may result from one or more of the following conditions: (1) facilities differ in the scale of their operations, (2) facilities differ in efficiencies, and (3) facilities are producing different products. Empirical studies are showing that not only does the motivation make a difference in the quality of care rendered to residents, but also that there are real differences in the scale and output of the not-for-profit sector respective to the class of all providers. For states to establish class systems independent of these variables, and/or to establish incentive reimbursement systems linked to classes that do not reflect the variables of scale and output is to curtail the not-for-profit participation in the program.

We call upon the Committee to make the necessary amendments to Section 21 of this legislation to allow for not-for-profit capital accumulation. We ask for

⁹ Pollack, *op. cit.*, p. 31-32.

a continued Committee monitoring of the implementation of Section 249 to stimulate conformance with the statute and to prevent encroachment on charitable resources. Additionally, we solicit Committee review of the influence of present reimbursement procedures upon the growth capacity of the long-term care field and to ascertain if adjustments are needed.

Section 22: Medicaid Certification and Approval of SNF's and ICF's:

We are concerned that Section 22 of S. 1470 might have an unintended result of forcing all skilled nursing facilities to be participating providers under Medicaid before being eligible for participation under Medicaid. It cannot be over-emphasized that any Congressional effort to unify long-term care policies and procedures under the two programs must address the differing focus of primary responsibilities. Again, we run the risk of having a single policy instrument to address two differing patient needs with the end result being an emphasis on the requirements to meet acute, episodic illness.

Furthermore, Section 22 continues to focus on the process rather than the patient/resident. While the process is important, let us not neglect the quality of the service provided. One of the key observations of the New York State Moreland Act Commission was:

"The survey inspections concentrate on the written word and can be passed largely by paper compliance. Thus of the 526 identifiable items in the 68 page Federal skilled nursing home survey inspection report, the Commission's review indicates that 290 items can be answered by the surveyor exclusively with reference to written plans, policies and records. In the Commission's view, only 30 of the 526 items might require direct observation of patients."¹⁰

The Committee might consider the advice of a recent Community Research Applications study of the levels of care in the intermediate care facilities program which concluded an interesting comparison of Federal and state standards for the ICF benefit, citing:

"This information suggests that there are at least three problems associated with the standards as they currently exist. First, they lack sufficient operational detail, so that wide latitude remains for local interpretation. Second, even if there existed uniform, operationally-specific regulations, these would be of little value unless all surveyors are trained, in uniform fashion, as to their use. Currently, there is considerable variation in the nature of deficiencies recorded, as a function of different approaches and orientations of different surveys. Third, as discussed in this report, all such changes will be meaningless unless they are preceded by the development of a uniform approach to patient screening and assignment to different levels of care."¹¹

While we do not oppose the proposed strengthening of the Federal presence in the Medicaid long term care program, we appeal to the Committee to recognize that the certification process alone is not a good measure of quality, and that reorganizing the certification procedure may have serious ramifications if there is not a firmer commitment to move toward standardizing the benefit.

Section 23: Visits Away from Institutions

The issue of home visits has generated a great deal of concern by some of the residents of AAHA member facilities. It seems that the implementation of the Medicaid policy with respect to home visits has generated much misunderstanding. While we welcomed the Department's attempt to clarify home visitation policies through regulations, it appears as if a number of states have instituted a more liberal leave policy than that of the Federal standard. Removing the barrier to such visits through statute might aid in clarifying the Department's policy.

Section 30: Establishment of Health Care Financing Administration

Our association set forth its position before this Committee in testimony last July. At that time, we endorsed the intent of the administrative reorganization; however, we cautioned that the distinction must be made between the need for uniformity and consistency in policy interpretation and the need for recognition

¹⁰ Report of the New York State Moreland Act Commission, *Regulating Nursing Home Care: The Paper Tigers* (New York State Moreland Act Commission on Nursing Homes and Residential Facilities, Albany, New York) October, 1975, p. 11.

¹¹ Community Research Applications, Inc., *A National Study of Levels of Care in Intermediate Care Facilities* (prepared for Health Services Administration, DHEW under contract number HSA-105-74-176) April, 1976, Chapter V, p. 43.

of diversity and heterogeneity in the characteristics of the population and living arrangements of those served by Medicare and Medicaid.

In our opinion, no reorganization of the current bureaucracy will straighten out the contradictions and anomalies now plaguing long term care unless and until it is accompanied by a better and more thorough understanding of the physical and social characteristics of elderly receiving or needing long term care services. Shuffling agencies around will not, for example, cure the type of problem created when health policies appropriate for the young or middle-aged population are glibly applied to persons suffering from three or four diseases on the average, and for whom deficiencies in family, social, economic and/or environmental circumstances often complicate recovery.

We have pledged our support to the administrator of the agency established by Executive Reorganization, and we trust that it will work toward a more responsive attitude with respect to the long term health needs of older persons.

Section 31: State Medicaid Administration

We commend the sponsors of this legislation for the proposed changes to improve the responsiveness of the state Medicaid programs. We note the Committee has slightly changed the provision for Medicaid redeterminations for the aged to provide for an annual, rather than a six-month redetermination procedure. While this allowance eliminates the mid-year redetermination, the process will still be administratively cumbersome for those individuals who are institutionalized for lengthy stays. The Committee might wish to consider a special waiver provision for redetermination for eligibility for individuals under certain circumstances, granting the Secretary discretionary authority to identify those situations and to exempt them from the redetermination process.

We are pleased that the Committee also recognized the problems which have continually occurred respective to slow-paying Medicaid agencies. Adequate cash flow can be a problem to institutional providers, and therefore, we commend the proposed requirements for claims processing.

While S. 1470 might not be the most appropriate legislative vehicle, we ask the Committee to review the options for enforcing the provisions of the Medicaid program. The penalty of cutting off state funds to force compliance appears to be so severe as to restrict its usage. For instance, in the General Accounting Office response to Congressman Pepper's inquiry on the issue of Departmental compliance with Section 249, the Comptroller General cited the dilemma of forcing compliance with the statutory implementation date pointing out that the cutting off of Federal Medicaid dollars would be more disruptive to the objective of reasonable reimbursement for quality care than would the delayed implementation.

Section 32: Regulations of the Secretary

Our association is on record as supporting the requirement of prompt development and promulgation of regulations. Certainly, the Section 249 cost related reimbursement regulations are a classic example of the Department attempting to thwart the implementation of a program mandated by the Congress through the vehicle of delayed rule making. Consideration might also be given to sunset provisions within Departmental regulations so as to require public review on a periodic (five year) basis. In this manner, the public and the Department can review the effect of rule making and the responsiveness of continued rules to changing circumstances.

Likewise, we have raised with the new administrator of the Health Care Financing Administration the possibilities of requiring state Medicaid plan changes to be published in the Federal Register. At a minimum, Regional office reviews of the state plan amendments required by Section 249 should be published with the rationale for the Regional office determination. We are appalled that during a recent meeting with Departmental officials, no one, including the individual directly charged with the review process, could respond to inquiries on plans which have been approved, whether plans have been submitted, and general reasons for plans to be remanded to the states. The move to open government must go beyond the development of regulations into the actual implementation of program.

Section 33: Repeal of Section 1867

S. 1470 proposes the abolition of the Health Insurance Benefits Advisory Council, which advises Congress and the Administration on Medicare and Medic-

aid matters, on the grounds that it has outlived its usefulness. We do not oppose the abolition of this council; however, we would prefer a restructuring of this committee to ensure its input within the policy process rather than its demise. HIBAC served a primary function during the formative years of Title XVIII, and we think it should be restored to its policy activities rather than terminated.

At the outset of this statement, we mentioned that following a section-by-section analysis of positions taken by our association with respect to the provisions of S 1470, we would offer several additional thoughts for Committee consideration.

The first two issues have been raised within the text of the above comments, and therefore they deserve only reiteration:

(1) We urge that Medicare's spell of illness rules be revised. If an individual cannot qualify for and is not receiving the Medicare Part A skilled nursing benefit, he should be able to break a spell of illness after 60 days, regardless of whether he resides at home or in an institution certified as a skilled nursing or intermediate care facility.

(2) We urge that in determining eligibility for Medicare Part B benefits, the individual's characteristics, rather than the institution's overall certification of license, should be the determinant. Persons residing in an institution who are not receiving skilled nursing benefits under Medicare Part A should be considered as residing in their own homes for purposes of qualifying for Medicare Part B benefits.

The third relates to the consideration within the House of Representatives of efforts at speeding the implementation of the national goal for uniform cost accounting as called for in Section 1502 of Public Law 93-641. While the logic of forcing actions to improve the data collection abilities of both the Federal and State agencies cannot be faulted, haste might have a detrimental effect upon the institutionalized. Our association has cooperated during the past year in a Health Resources Administration grant to the Battelle Human Affairs Research centers focusing on Cost Data Reporting System for Nursing Home Care.¹²

While our first finding that there is a widespread variation both across facilities and states in accounting and recording practices is hardly startling, the facts indicate that many variables which must be considered with respect to meeting patient/resident needs preclude an easy transition to a uniform accounting system. Among the factors that must be carefully reviewed will be the numerous instances, especially in non-profit sponsored facilities, where a residential facility is linked to the licensed, participating SNF/ICF facility. Likewise, size and relationship to other health facilities are factors that must be considered. We urge the Committee to proceed with caution on any suggested amendments to expedite uniform cost accounting for long term care facilities. This is not to oppose movement toward such a system, but to request the Committee carefully deliberate the impact of such steps upon the delivery system.

Finally, we call upon the Committee to carefully review the implementation of the PSRO program as it impacts upon long term care. The promise that a realistic application of PSRO standards will bring an approach which emphasizes combinations of services to promote maintenance of health and maximum functioning for the patient appear to have been missed by the proposed guidelines for PSRO review in long term care facilities. Our members have consistently observed that the application of the principals of a medical model overlook the essential needs of the long term care patient. The proposed House of Representatives amendments to remove the role of skilled nursing facilities from the operational aspects of the PSRO program, and to restrict PSRO activities in intermediate care facilities should be carefully explored. While we see merit in the strengthened state role in utilization control under Medicaid in ICFs, there is a potential for complications of such an approach with respect to dual certified facilities. Likewise, to remove the skilled nursing facility from any operational aspect of the PSRO program is to make these facilities even more dependent upon the hospital sector. The ramifications of these amendments must be carefully scrutinized.

We appreciate this opportunity to share with the Committee our thoughts on this important piece of legislation.

¹² Health Care Study Center, Battelle Human Affairs Research Centers, Cost Data Reporting System for Nursing Home Care (prepared for the Long Term Care Division, National Center for Health Services Research, Health Resources Administration, DHEW, under grant numbers HSO1114-01A1 and HSO1115-01A1) September, 1976.

STATEMENT OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS—SUMMARY AND RECOMMENDATIONS

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS BACKGROUND

The American College of Emergency Physicians (ACEP) was formed in 1968 by a group of physicians responding to growing public demand for improved emergency medical care. It was, in fact, this consumer demand which helped to stimulate the development of sophisticated emergency departments in America's hospitals, staffed by highly trained specialists in emergency medicine, and available twenty-four hours daily.

ACEP has grown rapidly and now has nearly 9,000 physician members whose primary interest is the delivery of competent and reliable emergency medical care. The public has wanted easy access to reliable medical care for emergencies at any time and, from this demand, has grown the field of emergency medicine and the full-time emergency physician.

The primary goal of the College is the attainment of appropriate physician education in emergency medicine and the adequate provision of quality emergency medical services to the American public. We owe our existence to the public, and we have tried to respond in an effective and meaningful fashion.

Very briefly, let us cite a few statistics which demonstrate the growing demand for emergency medical care. In 1954, there were 9,418,755 emergency department patient visits recorded by the American Hospital Association. In 1964, that number was 25,972,160 and, by 1974, the visits had increased to 67,056,890. During the ten-year period from 1965 to 1974, 471,196,006 patients were treated in hospital emergency departments. This is an annual growth rate of 10.31 percent.

The American College of Emergency Physicians has long recognized that quality patient care is our first responsibility. As emergency physicians, we have been and will continue to be participants in one of the most dynamic specialties in medicine. There have been exciting technical advances to assist emergency personnel in providing improved patient care. These technical advances include computer-based EKG interpretation, light-weight defibrillators, telemetry, high-speed automated laboratory tests, rapid X-ray developers, medical anti-shock trousers and a wide array of other developments.

Keeping pace with these technical advances has been an equal improvement in patient care resulting primarily from better training and the improved utilization of emergency medical personnel. Leading the way in emergency medical care has been an important role of the emergency physician.

We are proud of the role which ACEP has played in improving the educational opportunities available to emergency medical personnel. In 1968, when the College was first organized, there was such a need for better educational opportunities that the College founders dedicated much of their time to the fledgling organization. At that time, there were only a few courses that included rudimentary sessions on emergency medical treatment. In 1976, by way of contrast, ACEP coordinated the compilation of a course list which included some 189 educational opportunities for emergency physicians.

THE IMPACT OF IMPROVED EMERGENCY MEDICAL SERVICES

The problems of emergency medicine are truly community problems. There continues to be great need for sophisticated emergency medical services systems which begin at the accident site and continue until the patient is treated and released or hospitalized. Congress has recognized this need, in fact, and has done much to ameliorate the problems of inadequate emergency medical services through adoption of Public Law 93-154, the Emergency Medical Services Systems Act of 1973, and Public Law 94-573, the Emergency Medical Services Amendments of 1976.

The results of these efforts and the national attention have been dramatic. In fact, hospital emergency departments have become the public's yardstick for judging a hospital's quality of care and the quality of its medical staff. The public demands first-class emergency care, as we all know. On behalf of the medical community, the emergency physician has accepted this responsibility.

Prompt medical intervention is a significant determinant in the patient's ultimate outcome. The spin-offs from this nation's space explorations have provided medicine with technology enabling physicians to extend themselves to patients' bedsides, wherever these bedsides may be.

The emergency physician, by his ready availability, utilizes this technology to manage patients prior to traditional entry into the health care system. Improvements in the EMS system brought about by the early commitment to EMS by many professional organizations, as well as by Congress, have enabled patients, who would otherwise have died, to arrive critically-ill and injured, but alive, in hospital emergency departments, requiring the services of sophisticated emergency physicians and increasing the need for the traditional specialists who continue to provide definitive care.

THE MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT

The College is pleased to be of assistance to the Senate Finance Health Subcommittee as it deliberates the complex issues involved with the spiraling costs of American health care. As we review S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act, there are four specific areas of concern to the effective delivery of emergency medicine which we feel would be helpful to be understood by the distinguished members of the Subcommittee.

The first of these concerns is based upon the language of Section 10(a)(1), which proposes to add Section 1868 to Title XVIII of the Social Security Act. We note that proposed Section 1868(c)(2), which describes the requirements for participation in administrative cost-savings allowances in addition to reasonable charges, would exclude emergency physicians as presently stated. We believe that we understand the philosophical basis for excluding certain kinds of hospital inpatient and outpatient services traditionally provided by hospital-oriented medical practitioners.

However, we would like to point out the unique nature of the practice of emergency medicine. The emergency physician has the emergency department as his regular place of practice. No additional "outside the hospital" facility is customary. Yet, by requiring that an office or regular place of practice be maintained outside the hospital, the proposed law would effectively exclude participation by emergency physicians. This is a paradox which we believe to be inadvertent. We believe it to be appropriate to encourage emergency physician participation in Title XVIII provision of health care.

We recommend that emergency medicine be specifically designated to be eligible to participate in Section 1868(c) administrative cost-savings allowances.

Our second area of concern is found within Section 12 (b) and (c), which would effectively preclude emergency physician-hospital agreements based upon hospital billings for emergency physician professional services, wherein the emergency physician is reimbursed on a percentage of revenue agreement.

Many of our member physicians presently have agreements with the hospitals where they practice emergency medicine where the hospital bills for the physician professional fee on behalf of the physician as part of the bill for patient service in the emergency department. The basis for this practice rests, very straightforwardly, upon the recognition that it affords administrative economies.

The practice reduces the physician's administrative costs and, therefore, allows him to maintain a lower fee level than would be necessary if his administrative costs were increased.

We recognize that this practice is often based upon percentage of revenues agreements. However, it has been documented over a period of years to be a reasonable practice in the context of the uniqueness of emergency medicine.

To leave this prohibition in would have the potential for increasing administrative costs overall. This could occur when physicians are forced to look to the establishment of relationships with outside-the-hospital billing services. We feel that you should be aware that the stimulation of ancillary billing services, together with their built-in increases for administrative costs, are an implicit danger within the present wording of Section 12 (b) and (c).

We recommend that the language of Section 12 (b) and (c) be amended to allow hospitals to continue the practice of billing for hospital-based physicians' fees, where such practice is based upon an agreement between the hospitals and the physicians involved.

Our third point of concern is for an area not discussed by S. 1470. It is currently the practice in some states, such as California, for state Medicaid

agencies to take independent administrative actions in order to decrease professional fees allowed for emergency medicine procedures. This action results in a disparity between allowable professionals' fees for identical procedures in differing practice environments.

For example, if a family physician were to treat and suture a simple laceration during his regular office hours, at his office, he would be eligible for Title XIX reimbursement at a defined rate. However, because of these independent state administrative changes, an emergency physician would receive a reduced fee for the identical professional service at the hospital emergency department.

The agencies making these changes assert that the basis rests with the fact of smaller overhead costs for the practice of emergency medicine. This assertion simply is not true, and any investigation of the facts will show that emergency physician overhead costs, including liability insurance, uncollectable debts, legal expenses, continuing education activities, accounting expenses, and so forth are, if anything, higher than the average, certainly not lower.

In point of fact, these state agencies have singled-out emergency medicine for substandard reimbursements when the record often will demonstrate that emergency physicians do more for Title XIX patients yet receive less, even without this disparity, than any other physicians.

We recommend the addition of a parity amendment to S. 1470. This amendment should state that state Medicaid agencies shall reimburse physicians the same fee for the same services, irrespective of the practice location.

Our fourth and final area of concern actually is a dilemma which we wish to share with you. We wish to call to the attention of the distinguished members of the Subcommittee that, on the one side of our dilemma, Title XIX proposed to establish a system whereby the medically indigent are cared for within the mainstream of American health care practice.

On the other side, however, there is the uniqueness of emergency medicine. There is the fact that qualified emergency physicians are now available in hospital emergency departments virtually everywhere on a 24-hour-a-day, 365 days-a-year basis. There is now the fact that emergency physicians receive and treat *all* patients who present themselves, irrespective of patient need or patient ability to pay. We couple with these facts the additional fact that state agencies are struggling to decrease Title XIX reimbursements because of their enormity and the fact of real economic constraints. And to all of this we add the fact that patients who come to emergency departments to be treated by emergency physicians often have complaints which are within the scope of primary care, even though the patients perceive their needs for treatment as "emergencies".

At the same time, "general medicine", "family medicine" and other primary health care providers, including family clinics and neighborhood health centers become less willing to participate in Title XIX programs. Waiting times for patients to see primary care physicians increase, and there become increasingly longer delays in appointment schedules.

The net result is "superutilization" of hospital emergency departments: costs actually increase because emergency physicians will participate and the locus of treatment is the hospital emergency facility which generates cost in addition to the emergency physician's fee.

We share this dilemma with you; we do not have its solution.

Thank you for the opportunity to present our recommendations.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

We appreciate this opportunity to discuss this complex legislation which would make major changes both in the administration of, and the methods for determining levels of reimbursement under, the medicare and medicaid programs. The dental profession was active during the development and initial implementation of these programs and currently provides a significant amount of services under each of them. We are vitally concerned with problems which have developed with these programs and with the efforts which are and will be made to resolve these problems. Above all we are concerned that these programs provide the best care possible to eligible persons.

Health care financing administration (section 30)

The bill calls for the establishment of a separate organizational unit within the Department of HEW to be known as the Health Care Financing Administration. This unit would be under the direction of an Assistant Secretary for Health Care Financing. The unit would include the functions and personnel of the existing Bureau of Health Insurance, Medical Services Administration, Bureau of Quality Assurance, and Office of Nursing Home Affairs. The new Assistant Secretary would report directly to the Secretary and would have policy and administrative responsibility for the medicare, medicaid, professional standards review organization, and renal disease programs established under the Social Security Act.

Many of the changes proposed in S. 1470 with regard to the establishment of a Health Care Financing Administration have been implemented through the reorganization plan of HEW Secretary Califano. Including these reorganization provisions in S. 1470 will assure that the reorganization is carried out in the manner mandated by the Congress.

As set out in the statement of the American Dental Association to this Subcommittee last year, the Association is keenly aware of administrative difficulties which have arisen in the implementation of the various Social Security Act health care programs. We can agree that greater coordination in the implementation of these programs would be helpful. However, we are strongly opposed to the creation of an administrative unit which would not be under the specific direction of the Assistant Secretary for Health. It must always be kept in mind that the programs under consideration are health care programs and that it is the delivery of quality health care which is of paramount importance. Although administrative and other improvements can be made in these programs, these should always be accomplished under the guidance and direction of those who are responsible for insuring that the highest level of care possible is provided. We are very concerned that the establishment of an administrative unit which is headed by an individual of equal position to the Assistant Secretary for Health and which is given policy and administrative responsibility for these health care programs will lead to a decreased emphasis on the quality of health care and an overemphasis on the important but not overriding issues of controlling program costs and administration.

We feel that these concerns already are being realized through the difficulties being experienced in the Department of HEW with regard to the position of Assistant Secretary for Health. This recent experience has indicated an apparent downgrading of this position. We feel that it is of primary importance that such a downgrading not occur. We would support appropriate mechanisms for improved administrative and other efficiencies in these programs, particularly at the operational level. However, the overall responsibility for these health care programs must reside in the Assistant Secretary for Health and not in an individual who is primarily concerned with financing and cost controls.

State medicaid administration (section 31)

The provisions of this section of the bill are salutary in that, if states are able to comply with them, administration of the medicaid program would be significantly improved. Certainly one benefit resulting from the requirements that claims be paid quickly would be an improved cash flow for health professionals. Also it is certain that proper implementation of the requirements for periodic determination and redetermination of eligibility for medicaid benefits would assist in insuring that only eligible persons are receiving medical benefits. The information required relating to quality control, claims payment, and utilization of services also could be helpful in the long-term implementation of the medicaid program.

Our concern with these provisions is that they may prove too burdensome for the states to meet, although obviously this is a judgment which can best be made by those who are administering the program. We would be concerned that if the provisions are too strict, resulting in reduced federal payments to the states, this could further result in reductions in the benefits which are offered by the states and/or a reduction of payments under the medicaid program. In either instance the overall effectiveness of the program would be seriously hindered. We are concerned that the penalties authorized by this section could be very

deleterious to attainment of the overall goals of the medicaid program and believe that a much greater understanding of the ramifications of such penalties should be developed before they are authorized.

Regulations of the Secretary (section 32)

One of the major difficulties which we have faced with regard to rules and regulations promulgated by the Secretary of HEW has been a lack of appropriate time for comment on these rules. The Department has been implementing changes in the regulation writing process to allow greater input from interested parties. We hope that these changes will be beneficial.

Section 32(b) would allow the Secretary to indicate whether the prompt promulgation of a proposed rule or regulation is urgent. Where such a decision is made by the Secretary the rule or regulation would become effective within sixty days after publication of the initial notice of the proposed rule or regulation. Other rules or regulations would be promulgated according to existing law.

As indicated above, the American Dental Association has had considerable concern with the methods of promulgation of rules and regulations particularly relating to the amount of time allowed for comment. We believe that the importance of regulations which would be developed to implement this legislation is such as to require that the full opportunity for public participation as authorized under the Administrative Procedure Act be followed.

The development of regulations is a complex process often requiring several months of study. We believe that it is imperative that adequate time for comment on proposed regulations be provided in all cases. Rather than establishing special circumstances for urgent rulemaking we recommend that legislation be enacted mandating that at least sixty days be allowed for comment on all proposed rules and regulations.

In addition, we have concern with the requirement in the bill that regulations implementing S. 1470 would have to be promulgated and effective not later than 13 months following enactment of this bill. Although there have been times when the regulation development process has seemed to become bogged down leaving the implementation of various programs in a state of confusion, we would be opposed to a strict time limitation being statutorily mandated for the development of regulations. The development of federal rules and regulations is a complex process, particularly with regard to major legislation such as is proposed in S. 1470. While we commend efforts to assure the expedient development of rules and regulations, we would oppose any provision which mandates that regulations be developed within a time frame which may be unrealistic and may result in a lack of thoroughness in the development of these regulations.

Termination of HIBAC (section 33)

It has been our belief that the existence of an advisory council to the Secretary for the medicare program, such as the Health Insurance Benefits for the medicare program, such as the Health Insurance Benefits Advisory Council, which can bring to the Secretary the advice and recommendations of individuals who are involved with the program, is most commendable. With adequate financial and staff support, we believe that this body could contribute more to the solution of problems faced by medicare and other national health programs. We understand that there have been criticisms of the effectiveness of HIBAC but feel that the major problems of this Council are based on a lack of adequate support within the Department of HEW. We recommend that HIBAC be retained and provided with adequate staff and financial support.

Incentives to accept assignment of Claims (section 10)

The provisions of section 10 of S. 1470 are restricted to doctors of medicine or osteopathy. These provisions authorize certain administrative and financial incentives to participating physicians, who would be defined as physicians who agree: 1) to accept assignments for all claims made for treatment of individuals under part B of medicare, and 2) that the reasonable charge as determined under the medicare law would be the full charge for services. We feel that the incentives offered in this section to participating physicians may be attractive to certain providers. At the same time, we are opposed to the requirement that this provision apply to all claims or to none at all. A mandate that all claims be on an assignment basis could further reduce, rather than increase, the level of acceptance of assignments by physicians. Payment of adequate reimbursement would provide greater incentives for the acceptance of assignments.

Physician reimbursement (section 11)

Before discussing the provisions of S. 1470 which address reimbursement to individual practitioners under medicare and medicaid, we want to stress that provisions for reimbursement to dentists under these programs should be consistent with provisions for the reimbursement of physicians.

The American Dental Association is well aware of problems which have been raised because of different payment levels for services which are provided in metropolitan areas as opposed to payment for those same services when provided in rural areas. The medicare reimbursement mechanism, which is loosely based on the usual, customary, and reasonable (UCR) fee system, which is supported by the American Dental Association, has divided the nation into regions for which reimbursement levels are determined. Most states contain more than one region. Although it is true that an argument can be made that a single program should pay the same amount for any given services no matter where provided, it is also true that costs for providing those services do differ from one area to another, even within a single state.

We believe that the usual, customary, and reasonable fee system reflects differences in reimbursable amounts, based on provider costs and other similar factors, between urban and rural areas. While preferring the UCR system, we feel that the system being used in the medicare program which is inequitable in many ways, does reflect these differences in the costs of providing services. We do not feel that it is appropriate that the lid which is proposed by S. 1470 in section 11 be adopted. Although this section would not automatically grant uniform payment for services regardless of where they are provided, it would dictate allowable reimbursement levels under the medicare program on a basis which is unrelated to the usual, customary and reasonable charges made by health care providers in the area.

Relative value schedules

Section 15 of the bill proposes a two-part process for the development of relative values for procedures which are reimbursable under the medicare, medicaid, and maternal and child health programs. Initially the Health Care Financing Administration, with the advice of other large health care purchasers and representatives of professional groups and other interested parties, is to develop a system of procedural terminology in order to provide a common language describing the various kinds and levels of medical services for which reimbursement may be made.

Health practitioners associations then would be permitted to develop relative value schedules based on the services included in the procedural terminology system. After approval by the Health Care Financing Administration and the Secretary, the system of procedural terminology and relative values would be utilized by carriers in calculating reasonable charges under the medicare program. In addition the use of this terminology system and the relative value schedules would be permitted by any organization or person for purposes other than the medicare program.

The American Dental Association supports the concept of developing a system of procedural terminology. The Association has undertaken extensive activities with regard to the development of such a system for dental procedures. We feel that development of such a system is very beneficial in clarifying the administration of any health care program and encourage development of such a system for all fields of health care.

We have very serious questions and concerns, however, with the additional development of relative value schedules. The language in subsection C of section 15 of the bill reflects an awareness of the objections of certain federal agencies to the promulgation of relative value schedules. Although the legislation permits interested associations of health practitioners to develop relative value schedules, there is no assurance that the schedules so developed would in fact be those which are promulgated. It is our opinion that the provisions of section 15 in reality authorize the establishment of a national fee schedule which could be applied not only to the medicare program but also to reimbursement under private insurance programs. In addition to the policy concerns which have been raised with regard to relative value schedules and basic fee schedules by various agencies of Government, the American Dental Association strongly opposes the imposition of a national fee schedule. We must again reassert our support for utilization of the competitive usual, customary, and reasonable system as the only equitable and workable method of reimbursement.

Disclosure of Physician Payments (Section 44)

Section 44 would prohibit the HEW Secretary from disclosing, and provide discretionary authority with the state medicaid agencies with regard to disclosing, to the public information relating to the amounts that have been paid individual doctors of medicine or osteopathy under the medicare or medicaid programs. The American Dental Association feels that the effects of this disclosure policy in the past have been totally negative. Not only does this procedure improperly imply to the public a wrongdoing on the part of those who are named, but in addition the methods by which names have been disclosed have been grossly inaccurate. The implications of this disclosure have caused calculable damage to the reputations of the individuals involved. Without a showing of wrongdoing there is no valid reason for permitting such disclosure. We note that the provisions of section 44 are limited to the disclosure of names of doctors of medicine or osteopathy. It should be noted that the names of other health professionals including dentists have been disclosed under this HEW process. With an amendment to expand the scope of this provision to prohibit disclosing the names of dentists, the American Dental Association ardently endorses this provision.

We would like to discuss two additional issues which are of major concern to the dental profession. The first of these pertains to a situation which exists under the medicare law relating to the provision of covered services which legally can be provided by both physicians and dentists. Under medicare, there are certain services which dentists are specifically authorized to provide. Dentists are reimbursed for the provision of these services. However, there are other services which dentists are authorized by state licensing laws to perform but which, if provided by a dentist, are not paid for under the medicare program even though physicians are reimbursed for providing the same services. We urge you to amend the medicare law to provide that those services which a dentist is legally authorized to perform and which are covered under the medicare program should be paid for by medicare when provided by a dentist as they would be if a physician had performed them. Not only is the present situation inequitable for the dentist, it also reduces the opportunity for choice by patients. Legislation to correct this inequity in the medicare law has been introduced by Senator Robert Dole (R-KN), the ranking minority member of this Subcommittee and by Representative James Corman (D-CA) of the House Ways and Means Committee as S. 1197 and H.R. 3052. We should point out that this amendment does not authorize additional medicare benefits, it simply makes the system of reimbursement for covered services more equitable. We strongly urge inclusion of the relevant provisions in any medicare reform legislation which is developed by our committee.

The second major concern of the dental profession is the cutbacks which many states are now implementing in the medicaid program. These cutbacks, which are supposedly being made in the name of economy, have resulted in reductions or total deletions of adult dental care benefits in at least nine states. We strongly oppose the deletion or reduction of these benefits and are hopeful that mechanisms can be developed to prevent further reductions and to help restore dental benefits to the medicaid programs in those states where these cutbacks have occurred.

One of the effects of this reduction in dental benefits has been the development of a problem under medicaid which is similar to that which we discussed above with regard to medicare. In those states where dental benefits have been eliminated from among those offered under the medicaid program, services which are covered under medicaid if performed by a physician are not considered as covered services when performed by a dentist. Therefore dentists are not being reimbursed for providing these services. Correction of this inequity will not result in additional services being covered under medicaid. Instead correction would result in a much more equitable situation with regard to the provision of services under this program. All that is needed to correct this inequity is legislation providing that dentists be reimbursed for the provision of services which are included under the medicaid program when provided by physicians and which the dentist has the training and authority, under the state practice acts, to perform.

Again we emphasize that correction of this so-called overlap problem under the medicare and medicaid programs can be accomplished by making relatively technical changes in the medicare law and does not require the development of additional benefits under either of these programs. We have attached to this statement a copy of an amendment to accomplish these needed changes.

SUGGESTED AMERICAN DENTAL ASSOCIATION MEDICARE AND MEDICAID AMENDMENTS

The following suggested amendments are designed to assure that services provided by physicians which are covered under either the medicare or medicaid programs, or both, which also can be provided legally by a licensed dentist are treated as covered services under those programs when provided by a licensed dentist. Section (1) of these amendments is based on Section (1) of H.R. 11288 which was introduced by Representative Corman (D-CA).

Section 1. That clause (2) of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function or action, and who is acting within the scope of his license when he performs such function or action, or for purposes of the certification required by section 1814(a) (2) (E) of this act, or"

Section 2. Section 1905(a) (5) of the Social Security Act is amended by deleting the phrase "as defined in section 1861(r) (1)" and inserting in lieu thereof "as defined in section 1861(r) (1) except that physicians services include, and reimbursement shall be made for, those services for which reimbursement will be made when provided by a physician and which may be provided by a doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state in which he performs such services and who is acting within the scope of his license when he performs such services."

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS,
Washington, D.C., June 20, 1977.

HON. HERMAN E. TALMADGE,

Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Russell Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: The Committee on Health Care Matters of the American Institute of Certified Public Accountants (the Committee) wishes to submit the attached comments on the "Medicare-Medicaid Administrative and Reimbursement Reform Act" (S. 1470) for inclusion in the printed record of the June 7-10, 1977 hearings of the bill.

These comments are provided from the technical perspective of whether or not the sections of the proposed bill dealing with accounting matters would achieve the bill's stated objective. To the extent we believe that the proposed accounting provisions would not produce the expected result or where clarification is needed, we have provided the basis for our comment and, when practicable, a recommendation to remedy the technical fault. Accordingly, in view of this perspective, we are not in the position to comment on the merits of the reimbursement philosophy embodied in the bill.

The attached specific comments are limited to the following provisions of S. 1470:

Section 2 Criteria for Determining Reasonable Cost of Hospital Services.

Section 31 State Medicaid Administration.

Section 32 Regulations of the Secretary.

Members of the Committee would welcome an opportunity to meet personally with you and members of your staff to elaborate further on our comments.

Sincerely,

ROSCOE L. EGGER, JR.,
*Chairman, Federal Government
Executive Committee.*

WILLIAM FREITAG,
*Chairman, Committee on
Health Care Matters.*

ATTACHMENT

AICPA COMMITTEE ON HEALTH CARE MATTERS COMMENTS ON S. 1470, THE "MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT"

1. SECTION 2: CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

a. Accounting and reporting (page 3, lines 8 through 15)

Section 2 of S. 1470 contains the following addition to Section 1861 of the Social Security Act:

"(aa) (1) To more fairly and effectively determine reasonable costs incurred in providing hospital services, the Secretary shall, not later than April 1, 1978, after consulting with appropriate national organizations, establish—“(A) an accounting and uniform functional cost reporting system (including uniform procedures for allocation of costs) for determining operating and capital costs of hospitals providing services...”

These provisions address an extremely complex technical area in only the briefest terms. The manner in which these provisions are interpreted and implemented, however, can have a dramatic effect on whether or not the “Hospital Reimbursement Reform” provisions of S. 1470 are successful in meeting the legislative objectives of the bill. Accordingly, we recommend that consideration be given to increasing the specificity of these provisions including the requirement that generally accepted accounting principles be adhered to.

The need to clarify the intent behind the above provisions has been highlighted during recent proceedings within the House of Representatives concerning H.R. 3, “Medicare-Medicaid Anti-Fraud and Abuse Amendments”. Certain amendments were proposed for additions to H.R. 3 which would have, in part required the establishment of “a uniform functional accounting and statistical system”.

In commenting on these proposed amendments, we stated our opposition to any unqualified reliance on the use of a mandated accounting and statistical system which required uniform adherence to a functional chart of accounts to accomplish its objectives. In its May 12, 1977 letter of comment to Chairmen Rogers and Rostenkowski, the American Institute of CPAs stated that: “In our professional judgment the use of such a (uniform functional accounting) system would be extremely costly to implement and unnecessary to the purpose of the legislation. It remains our firm belief that comparative information sufficient to correct deficiencies in the present reimbursement cost reporting under Medicare, and Medicaid programs can, on a more expeditious and cost-effective basis, be obtained through a uniform reporting system which relates costs and units of service to function.”

b. Other criteria for hospital classification (page 4, lines 18 through 20: (aa) (1) (8) (iii))

This section should be modified to be consistent with Section 2(c) (1) (page 10, line 19 through page 11, line 6) of the bill, which provides for the specific elements to be considered in making appropriate comparisons of costs among various institutions.

c. Definition of routine operating costs (page 4, line 34 through page 5, line 8)

The term “routine operating costs” should be clearly defined; just describing its exceptions can lead to misunderstanding. One possibility is to use the definitions presently set forth in Medicare pronouncements. Further, we recommend that the definition clearly state whether “routine operating costs” include both inpatient and outpatient costs.

Also, the present definition excludes certain items from routine operating costs; however, it appears that all costs associated with those items have *not* been excluded. Indirect costs associated with the exclusions can be significant and, if not also excluded, can distort comparability of hospital routine operating costs in their respective groupings.

d. Calculation of average per diem routine operating costs (page 5, line 23)

The term “routine operating costs” as used for averaging purposes should be clarified as to whether such costs are based upon actual (incurred) costs or upon allowable (limited to 120% of the average) costs. For example, it is not clear whether actual costs incurred by a hospital in the current year which are in excess of the 120% allowable limit can be included in calculating average per diem operating costs for the next fiscal year.

e. Personnel and nonpersonnel components of routine operating costs (page 5, lines 19 through 21).

The separation of personnel and nonpersonnel components of operating costs does not appear to recognize that the nonpersonnel component may include such items as an outside dietary or laundry service. The cost of these services may be expected to be influenced by the area wage rate as is the direct personnel cost. If an adjustment is not provided for in these areas, costs for similar functions will receive different treatment.

f. Exclusions from calculation of average per diem routine operating costs (page 6, lines 4 through 10)

The exclusion from this calculation of any hospital having significant understaffing problems presupposes the existence of some generally accepted staffing standards. We are unaware of standards which would allow for this determination and point out that without these standards there is the danger of being unable to distinguish the highly efficient institution from the understaffed institution.

g. Retrospective adjustment at end of fiscal year (page 7, lines 16 through 22)

The unidentified, but apparently long, time lag required for the development of "adjusted" per diem payment rates may cause serious problems. This approach could delay the final determination of allowable routine operating costs until well after the end of the hospital's fiscal year. This would certainly delay ascertaining the results of operations by the hospital and, would hamper the independent certified public accountant in rendering a timely opinion on the fairness of the results of operations.

In addition, unless the hospital is able to make a timely determination of its current year's allowable operating costs, it will be severely handicapped in planning and budgeting its operations for the succeeding fiscal year. This will prevent management from carrying out its basic responsibility to its governing board and its community as envisioned by Section 234 of the Social Security Amendments of 1972 (Public Law 92-603).

To facilitate effective financial planning by hospitals and so that budgets and financial statements may be prepared on a timely basis, we suggest that a means be developed which would allow a final determination of a hospital's payment rate before the beginning of its fiscal year. This is supported by the observations of the Subcommittee on Oversight of the Committee on Ways and Means of the U.S. House of Representatives in their "Report on Medicare Cost-Savings Experimentation" issued on January 3, 1977.

h. Recovery from other payors (page 13, Lines 9 through 24)

Paragraph (f) stipulates that providers may not increase amounts due from others to offset reductions made under Section 1861 (aa) in payments by the Medicare and Medicaid programs. This section includes a number of complex limitations, only some of which it appears will result in reductions which could be measurable with reasonable accuracy. The intent of this paragraph is not clear, and it probably would not be practicable to implement the intended restriction if the paragraph is interpreted literally.

We recommend that this paragraph be reconsidered. If it is still deemed appropriate to retain its substance, we recommend it be rewritten to clearly indicate the intent. Further, any such restriction should be related to specific limitations which would result in measurable reductions.

i. Incentive provisions (section 2)

The Committee is concerned that the incentive provisions of the bill will be extremely difficult to implement because of the array of adjustments, exclusions, and other factors, including retrospective and prospective features. It is recommended that these provisions be reconsidered with a view toward achieving greater simplicity and ease of implementation.

2. SECTION 31 : STATE MEDICAID ADMINISTRATION

Improved claims payment procedures (page 55, line 4ff)

We recommend a time limit be provided for the required post-payment claims review procedures. Claim denials applicable to the prior, or in some cases, a second prior fiscal year have been a source of an ongoing problem in the fiscal management of providers and in the preparation and audit of provider financial statements.

3. SECTION 32 : REGULATIONS OF THE SECRETARY

Effective date (page 63, lines 4 to 13)

Consistent reporting and cost determination cannot be accomplished unless the implementation of regulations occurs at the beginning of providers' fiscal years. We assume that this is the intent of the effective dates referred to in the proposed legislation, and suggest, therefore, that the proposed legislation should require that the resulting regulations become effective for providers' fiscal years beginning on or after the first day of the 13th month following adoption.

AMERICAN LUNG ASSOCIATION,
New York, N.Y., June 8, 1977.

Senator HERMAN TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR TALMADGE: We note that Section 42 of S. 1470 provides for specific legislative authority for regional pediatric pulmonary centers. The American Lung Association adopted a resolution several years ago in favor of such authority. We are pleased that you have reintroduced this provision to assure a more certain future for these important centers and are happy to have this opportunity to extend our support.

Pediatric pulmonary centers perform valuable services for our child population. In many areas, they are the only consultative resource available to community practitioners on the respiratory conditions of their young patients. The delivery of advanced diagnostic/treatment methods to young persons ill with respiratory conditions often means that these patients can continue to function and not face chronic invalidism. In cases of infant respiratory distress syndrome, such services can be life saving.

There is evidence that frequent episodes of acute respiratory disease in children can lead to chronic pulmonary disability. For this reason, children should have high quality diagnostic work up and proper therapy as soon as possible.

Although existing centers vary somewhat in their specific resources, the conditions which they treat range from serious neonatal conditions, where intervention must be prompt and skilled if the child is to be saved, to chronic conditions such as cystic fibrosis and asthma.

Our medical society, the American Thoracic Society, is concerned with standards of medical diagnosis and care of children with asthma and related diseases. Programs of lung associations frequently include support of local efforts aimed at improving the care of these children. Lung associations are very aware of the paucity of medical resources for such children in many areas of the country.

With President Carter's emphasis on preventing disease in children, it is important to recognize the present and potential importance of pediatric pulmonary centers. The 11 centers now receive approximately \$2 million in federal appropriations, the same amount they have been receiving for years. Originally under the Regional Medical Programs and later transferred to the Office of Maternal and Child Health, the support of the centers has been dependent on administrative priorities. We believe the time has come to give them some degree of security so that plans to increase their coverage of the population can be carried out. The present limited number of centers cannot achieve comprehensive coverage.

Our organization has two specific comments about Section 42. One relates to the requirement that centers be a part of or affiliated with an institution of "higher learning". We believe that centers should be connected only with medical schools or medical centers affiliated with medical schools in order to assure high quality treatment. We would like to request that this change be made either in the wording of the provision or that the intent be covered in the Committee report.

The other concern relates to the sense of urgency the American Lung Association feels about obtaining this legislative authority. It is our understanding that your committee will be conducting hearings on H.R. 3 shortly. We would like to request that Section 42 be made a part of H.R. 3 in order to expedite its implementation.

If passed, Section 42 will help build a new future of pediatric pulmonary care. The American Lung Association is appreciative of your authorship of this provision and is happy to support it.

Sincerely yours,

WILLIAM F. ROBERTS,
Acting Managing Director.

STATEMENT OF THE AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, INC.

(By Allan R. Fox, D.O., President)

DEAR MR. CHAIRMAN: As President of the American Osteopathic College of Pathologists, I am writing to submit our views on S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

Our College is composed of osteopathic physicians who by their post-doctoral training have achieved the status of "specialist". Specifically, the osteopathic physician pathologist possesses a learned expertise in the laboratory phases of medical practice, and who integrates this special expertise with patient care, either directly by himself, or through the physician who is directly attending the patient.

While the osteopathic specialty of pathology is comparable, in degree of training and certification to other specialties, in other respect it is a very unique specialty.

In the osteopathic profession, virtually all pathologists are "General Pathologists", and are "Hospital-Associated". The few exceptions practice in one of the subspecialties of pathology, for example, research pathology, industrial pathology, forensic pathology, etc. Thus, we are first unique in the restriction of our practice setting.

Next, the specialty of osteopathic pathology is unique in that, while it is at the hub of nearly all hospital services, it involves the least direct patient contact of all specialties. The Professional services of the "Hospital-Associated" pathologist vary with the size of the hospital, the extent of its pathology service and the scope of his services, in providing health care to the patient. These services may include, but are not limited to, the following:

1. Direct operating room and bed-floor medical patient consultation.
2. Diagnosis and interpretation of all materials derived or expressed from the human body.
3. Interpretation of clinical findings, and laboratory data whether performed by himself or other technical personnel, in order to establish a diagnosis for the patient's ailment, and a therapeutic program to be conducted by the attending physician.
4. Performance of autopsies and interpretation of the findings to constantly improve the professional confidence in medical practice and knowledgeability in all disciplines of medical practice.
5. Maintaining the proper quality control programs necessary to insure accurate and reproducible results of all laboratory examinations.
6. Responsibility for organizing and maintaining a proper technical staff in the laboratory. This function requires ongoing teaching and training of paramedical staff, the instituting and monitoring of all new procedures, medico-legal responsibilities of work performed by himself or others under his jurisdiction, etc.
7. Fiscal management of the laboratory to control the cost and expenditures at a reasonable level, as required by third-parties.
8. The execution of other duties, beyond the customary activities of general staff members, which are required, either by law or directive. These duties may include the maintenance of a tumor registry, the statistical documentation of surgical tissue analysis, and program teaching of resident and visiting staff, etc.

Because of the uniqueness of our specialty several unique patterns of service and methods of compensation therefore have evolved, as working agreements between osteopathic hospitals and their "Associated Pathologists".

All of the foregoing brings us to our concern over the provisions of S. 1470 which relate to "Hospital-Associated" physicians.

We, in the American Osteopathic College of Pathologists, are not blind to the acceleration in hospital care costs during the past several years and are fully aware of the impact of these increases on the administration of the Medicare and Medicaid programs. We are also aware that increases in laboratory services have contributed to the overall problem of increasing hospital costs. We must respectfully submit, however, that neither the increase in laboratory costs nor the overall cost in patient care have been significantly affected by the level of compensation of "Hospital-Associated" pathologists.

We do not contend that there have not been isolated instances where hospital-associated pathologists have obtained excessive compensation, nor do we condone such practice. We do affirmatively assert, however that the varying contact forms presently employed, most hospital-associated pathologists are now fairly and reasonably compensated for their highly specialized and unique services. I would add, that the American Osteopathic College of Pathologists does not, and has not at any time, endorsed the use of any particular method of compensation, but rather accepts the premise that a pluralistic approach is most reasonable, since circumstances affecting reimbursement policy may differ from hospital to hospital.

While we fully sympathize with the Congress' feeling of obligation to curtail rising hospital costs in order to concomitantly curtail Medicare and Medicaid costs, we do not feel that the provisions of Section 12 of the bill as they relate to pathology services are either reasonable or fair. As we have said above, pathology services are unique in their remoteness from direct patient contact. We feel it is most unfair and frankly, just plain wrong, to limit reimbursement to pathologists to instances "only where the pathologist personally performs, acts or makes decisions with respect to a patient's diagnosis or treatment which required exercise of medical judgment". As we have said above, the scope and function of our professional services is far more pervasive and far less easy to categorize, in reality. We strongly maintain that compensation to the "Hospital-Associated" pathologist must, in all cases, reflect the true extent of the total activities and service rendered by him, since, ultimately, his total effort enures to the benefit of the patient.

It is our belief that the adoption of Section 12 of S. 1470, as presently drawn, would not only be an injustice to those now practicing as "Hospital-Associated" pathologists, but in the long run, would precipitate a drastic decline in the number of qualified physicians entering the specialty. The specialty requires an expertise acquired only after years of training and study. If an immutable and inequitable level of compensation is established and perpetuated by Federal Act, then prospective candidates for residencies in pathology are likely to pursue more lucrative specialties requiring no more training. Any depletion in the number of osteopathic pathologists now, or in the foreseeable future, would jeopardize the high quality of health care being delivered in osteopathic hospitals.

Recently, the American Osteopathic College of Pathologists queried Pathology Department Chairmen about the type of compensation arrangement between the hospital and the pathologist being used by the institution involved. Of those responding 52 percent are salaried employees of the hospital. The remaining three categories are as follows:

- (a) Pathologists being compensated by percentage contract are 22 percent.
- (b) Pathologists being compensated by a fee-for-service basis are 8 percent.
- (c) Pathologists being compensated by a combination of the above methods are 18 percent.

As you can readily see, most osteopathic pathologists are compensated as salaried hospital employees. However, the AOCF strongly supports pluralistic compensation methods. We believe it is far more preferable to permit hospitals and pathologists the opportunity to negotiate varied forms of compensation which may accommodate the individual hospital's circumstances.

The location of the pathology laboratory, size and activity of the laboratory and the hospital, dictates that pluralistic compensation methods are necessary rather than mandating pure salary arrangements which have proven to be unworkable in many instances.

The AOCF does, however, urge the Subcommittee to give close attention to the fee for service concept based on relative value schedules including the professional component of all test performed in clinical pathology and anatomical pathology laboratories. This method allows closer scrutiny by the hospital administrator and the government as well as providing compensation rates commensurate with the professional status of the pathology specialist.

One final point, osteopathic hospitals are generally smaller community oriented facilities providing a continuum of the primary care offered in the individual osteopathic family practitioner's office. Our patients are essentially from the middle and lower income levels. We do not, unfortunately, benefit from endorsements and other funds as do many allopathic hospitals which tend to be larger, well established facilities and often university affiliated. Donations of costly technologically advanced equipment is virtually non-existent. In many cases it would be a burden too large to bear for our hospitals to include in their budget a salary for pathologists which is competitive with the specialty compensation on a whole. Therefore, we once again reiterate the desirability of other forms of compensation.

For all the reasons we have recited, we respectfully request that this Committee consider an alternative approach to the language of Section 12 which will insure truly equitable reimbursement.

Your serious consideration of the issues we have raised herein will be most appreciated.

STATEMENT OF AMERICAN OSTEOPATHIC COLLEGE OF RADIOLOGY

(By Martin S. Landis, D.O., Past President)

This statement is offered on behalf of the approximately 370 osteopathic radiologists who are members of the American Osteopathic College of Radiology. The College is grateful for the opportunity to state its views to the Senate Subcommittee which is presently reviewing U.S. Senate Bill No. 1470.

The American Osteopathic College of Radiology ("College") is the national professional society of osteopathic physicians who specialize in the practice of radiology. The College has the responsibility for supporting activities leading to the most efficient and economical delivery of the services provided by its members in accordance with the highest professional standards of medical care. We are well aware of the need for legislative improvements in federal funding programs which provide payment for health services. We also recognize the spiraling costs of the equipment, materials and support services necessary for the practice of radiology. Therefore, we are certainly in accord with the purposes of S. 1470, and we offer this statement in the spirit of cooperation in an effort to make this legislation the best legislation possible for the achievement of medical cost containment and the retention of the highest quality of medical care.

The members of the College are also members of other medical societies including the American Osteopathic Association. Our members are engaged in both purely hospital-based practice and purely private practice with some members having a combination of both types of practice. We understand that the American Osteopathic Association will be providing this Committee with a statement dealing generally with the practice of osteopathic medicine in relationship to S. 1470. We will confine our comments to those sections of S. 1470 directly affecting the practice of osteopathic radiology.

In preparing this statement, we have had the benefit of reviewing a draft of a statement submitted to the Committee by the American College of Radiology, and we will make reference to that statement at appropriate places in our statement. For the sake of brevity, we will refer to that statement as the "ACR statement" whenever we refer to it in our statement.

We would like to note one other significant fact concerning our position with respect to S. 1470. Normally, osteopathic physicians and osteopathic hospitals are engaged in primary care and not in large scale medical research. Osteopathic hospitals tend to be smaller than other hospitals, and they often are less expensive than other hospitals. Thus, our members not only believe in the purposes evidenced by S. 1470 but also have actually consistently practiced the concepts embodied in S. 1470. It is important to keep this in mind so that you will understand the perspective from which we comment on Section 2 and on the other sections of S. 1470.

We agree with the ACR statement that the provisions in Section 2 of S. 1470 which permit a state reimbursement system to supersede the federal system need to be expanded upon to provide assurance that there is a standard approach adopted by the various state systems which guarantees the same concern expressed by the federal government for the maintenance of readily available high quality medical service at the lowest cost possible. We also share the ACR's concern with the conflict between the deletion of the costs of interns, residents and non-administrative physicians from the term "routine operating costs" in Section 2(b) and the provision of Section 2(e)(2) which refers to all revenue sources for hospital services. It would appear that a fair solution to the problem would be to permit the inclusion of cost of interns, residents and non-administrative physicians within the term "routine operating costs."

Section 4(c) raises the specter of having to comply with the requirements of several different planning agencies with all the delay that such compliance would involve. In fact, it is even possible that compliance with one agency might make it impossible to comply with another agency's requirements. We would suggest that the Act designate a particular agency which would have sole authority for approving or rejecting proposed capital expenditures. Although the 180-day requirement for action by the various agencies does help somewhat with the delay problem, it would seem better to put this authority within the jurisdiction of a single agency which would have a time limit of perhaps 90 to 120 days within which it would have to act or else the expenditures would be deemed approved.

We are certainly encouraged by the provisions of Section 10 which make real strides towards streamlining the payment system to eliminate some of the current inequities. We also appreciate the provisions which simplify the procedure for submitting claims. However, we do not feel that the discrimination against X-ray services which is contained at the end of Section 10(a) is justified. To fully implement the purposes of the Act, the \$1.00 administrative cost saving allowance should certainly be extended to all X-ray services without regard to whether they are for hospital in-patients or out-patients or are performed outside the office of the participating radiologist. The current language of that section seems both unfair and inconsistent with the purposes of the Act.

Section 12(a)(1) also contains discriminatory language which discourages efficient practice by the use of qualified technical or paramedical assistants. The physician should not be forced to perform services that should not really require his time and a patient should not have to bear the extra expense connected with a physician's performance. We would suggest that this problem could be solved by changing the word "and" which precedes clause (B) of the existing Section 12(a)(1) to "or" or by deleting clause (B) completely. We have no problem with the requirement that the service must be either personally performed by or personally directed by a physician because this is in keeping with the normal radiological practice. However, the additional requirement that the service be of such a nature that its performance by a physician is both customary and appropriate is not at all reasonable in view of normal radiological practice. There are a number of procedures which would be personally *directed* by a physician for the benefit of a patient which would not be of a nature that would make them customarily or appropriately *performed* by the physician himself. A few examples of this are provided in the ACR statement.

We concur in the philosophy behind the provisions of S. 1470 which deal with percentage contracts between a hospital and a physician. However, Section 12 of S. 1470 does not deal adequately with the situation where a percentage arrangement may be essential such as a small rural hospital. This same situation also has the additional problem of not providing an adequate standard of comparison as required by Section 12 since there may not be physicians actually employed by the hospital. This means that there would be no salary to which the percentage arrangement could be compared.

Furthermore, in some states it is illegal for a hospital to practice medicine. It follows from that fact that a hospital may not have doctors in its employ in those states. What comparison could be drawn in those situations between a charge based on a percentage arrangement and a salary paid to a physician if he had been employed by the hospital?

We are certain that Section 12 is not intended to refer to any compensation arrangements other than percentage arrangements. However, perhaps Subsection (c) of Section 12 could be rephrased to make it absolutely clear that it is not referring to any fee for services or compensation based on a relative value schedule. Conceivably, the argument could be made that where the basis for compensation is a relative value schedule, that this is "related to the amount of income or receipts of the hospital." To eliminate such an erroneous interpretation of Section 12, perhaps the phrase "percentage of the income of receipts" could be substituted for the existing language.

We concur with the ACR statement on Section 15 of S. 1470. We believe that any professional society which has had a relative value scale should be permitted to submit this scale to the Secretary of Health, Education, and Welfare without waiting to be asked by the Secretary to submit this information and without fear of reprisal on the part of the Federal Trade Commission or the United States Justice Department either for the violation of an existing consent decree or by the initiation of a new investigation or legal proceeding. We also agree that for such information to have validity, the society must have the right to test the figures contained in such a scale on at least a limited basis before they are submitted to the Secretary.

We agree with the ACR statement in commending the provisions of Sections 31, 40 and 41 of S. 1470. We especially want to emphasize the necessity to cover transportation of patients to and from special types of treatment and care facilities besides the one type mentioned in Section 41.

We wholeheartedly approve of the intent expressed by Section 44 of S. 1470, and we would suggest that the words "be required" following the phrase "the

State title XIX agency" be deleted so that the State agency will have no greater power to make available this information to the public than does the Secretary of Health, Education, and Welfare.

We sincerely appreciate this opportunity to present our comments on S. 1470. We will be happy to provide additional comments if you so desire, and we wish your Subcommittee success in your efforts to prepare this significant legislation for passage by the United States Congress.

STATEMENT OF AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

This statement is presented by Michael F. Doody, President of the American Osteopathic Hospital Association, 930 Busse Highway, Park Ridge, Illinois 60068.

The AOAHA maintains its Headquarters in Illinois, with an office in Washington, D.C., and represents the 203 osteopathic hospitals which are located in 28 states. These institutions serve as the primary institutional care facilities for those patients (individual consumers) who choose to receive their health care from one of the approximately 15,000 practicing osteopathic physicians in the country.

Osteopathic physicians comprise a second school of medicine. The osteopathic profession is a politically and philosophically separate and administratively independent school of medical practice. Osteopathic physicians are largely providers who concentrate in the areas of general practice and family medicine. Approximately 85 percent of all practicing osteopathic physicians are engaged in the delivery of primary care. Osteopathic physicians, numbering slightly over 4 percent of all the physicians in this country, represent in excess of 17 percent of all general practitioners.

The 203 osteopathic hospitals provide more than 23,400 in-patient beds and employ approximately 62,000 people. In 1976, osteopathic hospitals had more than \$1 billion in total expenses and rendered health care services for more than 810,000 in-patient admissions and 3.1 million out-patient visits. Osteopathic hospitals are cost conscious institutions whose primary objective is the delivery of quality health care in a cost-effective manner.

A large number of osteopathic hospitals are engaged in the teaching of interns and residents and as such represent an important community health resource. Many of our hospitals are located in rural or semi-rural areas and provide a very necessary community health service. In some instances, the osteopathic hospital is the only hospital present within the community.

INTRODUCTION

This Association supports the basic premises which prompted the distinguished Chairman of this Subcommittee to introduce S. 1470:

We cannot continue with a program which increases in costs faster than the rate of rise in federal revenues.

We must make Medicare and Medicaid more efficient and economical or benefits will have to be ultimately reduced.

We must avoid arbitrary controls on payments to hospitals.

We must provide incentive payments to encourage efficiency.

Such changes must be made prior to any expansion of the federal role in providing more health insurance to more people since without such changes any expansion would be an open invitation to fiscal disaster.

The American Osteopathic Hospital Association and its Member Hospitals have consistently supported long-term efforts to overhaul the present hospital reimbursement system. We believe the present practice of grouping hospitals according to bed size and geographic area should be altered to include such other factors as patient mix, level of sophistication and scope of services, labor costs, and the extent of teaching programs. In addition we have often advocated the undertaking of a positive program to develop incentives for hospitals to participate in programs which have proved themselves to be effective in containing hospital costs, including prospective payment systems.

Under the present system, if two hospitals of similar bed size in the same geographic area have a variation in costs, at least one is assumed to be inefficient and have poor management and unreasonable costs. This is a premise which we

cannot accept. Variation in costs between hospitals is not indicative of poor management or inefficiency. Other factors, recognized in S. 1470, contribute to and affect the efficient delivery and cost of hospital and health services. This Association supports government efforts to reduce reimbursement to institutions where it can be shown that costs are unreasonable and the result of marked inefficiencies. We are in sympathy with the concern expressed by the Senate Finance Committee in its report on the Social Security amendments of 1972: "... when the high costs (from hospitals) flow from inefficiency in the delivery of needed health services the institution should not be shielded from the economic consequences of its inefficiency." The basic issue is the determination of what is or is not a reasonable cost and what is or is not efficient management. It is this issue which S. 1470 attempts to address, and it is this issue which we address in our testimony today. Our remarks are directed at the goal of providing the best possible health care through a cost-effective, well-organized system. For purposes of organization, our thoughts are set forth on a section-by-section basis, corresponding to the number system in S. 1470.

Section 2: Criteria for determining reasonable cost of hospital services

Before commenting on this section of S. 1470, it is appropriate here to discuss the reasons behind rising health care and hospital costs.

The amount hospitals must pay to meet operating expenses has risen steadily over the past several years. The major components of the rising costs include such things as energy (*up more than 20 percent per year since 1973*), food, premiums for malpractice insurance (*up more than 800 percent in the past seven years*), and labor costs. The hospital market basket is an expensive mix of goods and services the costs of which move at a greater rate than the overall Consumer Price Index, and it is a market basket especially hard-hit by inflation in the general economy.

It is commonly stated that the cost of hospital care has risen over the course of the past ten years at a far faster rate than the overall rate of inflation or the Consumer Price Index. However, those who make this statement generally fail to recognize that a patient day of care in 1977 is a far different product than a patient day of care in 1967. Hospitals are not producing a uniform product such as the steel or meat packing industries produce. The hospital product, *a patient day of quality health care*, is an extremely complex item to produce and it is a product which is constantly changing and improving.

Another factor which contributes to rising hospital costs is intensification of services in terms of sophistication of technology. Intensification is the result of the change in the mix of patients treated—we are able to treat many previously untreatable maladies—and a result of new technologies heretofore unavailable—open heart surgery, organ transplants, renal dialysis equipment and others. Such technological improvements in care have all contributed to increased per unit costs.

Volume is another major factor contributing to increased costs. We are living longer and therefore are more likely to contract illnesses which require greater care. We have expanded benefits, broadened coverage and increasingly we have eliminated economic barriers to the utilization of the health care system. As a result, hospitals all over the country provide care for millions who cannot pay or who pay only in part.

The hospital customer, unlike other customers, rarely shops price. Once the decision has been made to enter the hospital, he demands nothing less than the best the industry and its sciences can offer, even miracles. There is no patient demand for a cheaper model. And it must be remembered that it is the physician, not the hospital, who decides what tests, treatments and other procedures will be utilized.

Finally, there is one other area which we believe contributes to rising hospital costs—modernizing the hospital plant and maintaining its service capacity. These costs have risen rapidly too because of changes in the nature of facilities, construction inflation and the increased costs of capital. The trend in construction has been away from wards toward semi-private and private rooms and toward replacing obsolete facilities with modern ones which provide better treatment and patient safety. Construction costs are up both in terms of materials and labor. Finally, capital costs have generally increased because of the need to use debt financing, a result of the declining availability of grants and philanthropy.

Osteopathic hospitals have taken action to contain costs. Our hospitals have taken a variety of cost-cutting steps such as mergers, shared services, the develop-

ment of ambulatory care programs, cost containment reviews, and many other internal management programs. In addition, there are a number of governmental and voluntary controls in existence such as accreditation requirements, reimbursement controls, certification of need for facilities and services, that are all directed at containing costs.

Section 2 of S. 1470 is indeed far-reaching and the most significant for hospitals. We applaud the Chairman for his insight and his attempts to develop an effective hospital reimbursement system. While any classification system for hospitals is by its very nature arbitrary, the proposed new method of reimbursement for routine operating costs for hospitals embodied in S. 1470 seems to us to be a major step forward in the development of an equitable system. Of all the proposals made to date, this appears to this Association to be one of the fairest yet devised, and it is certainly vastly better than the classification system presently in place. We are particularly pleased to see the exclusion of variable cost elements such as education and training, energy, and malpractice.

EDUCATION AND TRAINING

In the area of education and training, Section 2 amends Section 1861 of the Social Security Act by adding a new subsection (aa). The amendment excludes from 'routine operating costs' in (aa) (2) (C) "costs of interns, residents, and non-administrative physicians." It is our belief that criteria should be set forth in this section to determine what costs associated with interns and residents will be excluded. For example, it is unclear whether the indirect administrative costs incurred by the institution associated with these teaching programs will be excluded. This Association believes they should be, and we urge the Subcommittee to clarify the intent of this section.

ENERGY

In determining routine operating costs, Section 2 of S. 1470 does exclude "energy costs associated with heating or cooling the hospital plant." This Association questions the limitation of this provision to just heating and cooling. Hospitals use enormous amounts of energy, particularly electricity, over and above those amounts used for heating and cooling. While we commend the Chairman for taking the first step in this area, we strongly recommend consideration of a hospital's true, overall energy consumption, not just that portion devoted to heating and cooling.

MALPRACTICE

The exclusion of malpractice insurance expense from routine operating costs in (aa) (2) (E) is a welcome addition to S. 1470. We believe, however, that this section should specify that the total costs of malpractice be excluded. At a minimum this should include: (1) professional and comprehensive general liability premiums, usually covered under a single policy; (2) the total costs associated with a self-insurance program, whether by an individual or group of institutions, including moneys contributed to a reserve in lieu of premium payments and the costs associated with legal, actuarial and consulting services involved in both setting up the reserve and its ongoing maintenance; and (3) costs associated with loss control programs.

One final note regarding exclusions from routine operating costs. Subsection (aa) (2) (F) excludes "ancillary service costs," but does not define the term. We suggest that such a definition be included in the final measure as a clarification of the intent and scope of this section.

There are other variable cost elements which we would urge this Subcommittee to consider, including the cost impact of government-mandated programs (e.g., health planning, PSRO's, and utilization review), and charity care losses. Each of these areas contributes heavily to hospital costs and does so more heavily in some areas than others. Adjustment of routine operating costs to take into account the effect of area wage differences is also an important factor and we are pleased that this issue is addressed in S. 1470. We would also urge that the cost of an employee benefits package be included when calculating the effect of area wage differences. These employee benefit packages vary widely in scope and coverage and can have a significant impact on hospital costs.

This Association supports the application of this Section to Medicaid as well as Medicare as a welcome step toward federalizing Medicaid. We are concerned,

however, that the actual language of the legislation is not specific enough to assure state acceptance of and participation in the proposed classification and reimbursement systems. We believe it is essential that the legislation mandate full compliance with the proposed new systems as a condition of state participation in the Medicaid program.

As mentioned previously, this Association favors the incentive approach—rewarding hospitals whose comparable routine operating costs are less than the mean and penalizing those whose costs are substantially above the mean. The phase-in approach will allow hospitals time to adjust and we commend the Chairman for his foresight in establishing this concept.

We are somewhat concerned about the system of classification of small hospitals, those in the 5- to 24-bed category, and those in the 25- to 49-bed classification category. Many hospitals in these categories are located in rural or semi-rural areas and compliance with Federal regulations is often very difficult for these institutions. Attempts to comply with HEW regulations in order to qualify for participation in the Medicare program have resulted in great expense and in some cases closure of the facility altogether. Despite some HEW attempts in certification of access hospitals, it became apparent in the early 1970's that some rural hospitals were having difficulty complying with nursing staff requirements and other regulations.

HEW is not eager to make provisions for the problems of these small rural hospitals and therefore such guidance will probably come only through an amendment to the Medicare regulations. Such amendments would have to create a new classification for rural hospitals. We recommend that this Subcommittee consider this problem, and attempt to make some provision in the categories of classification which would recognize the inherent problems faced in rural areas.

We are also concerned about the classification of hospitals according to type with regard to (aa) (1) (ii) (II) which reads: "hospitals which are the primary affiliates of accredited medical schools (with one hospital to be nominated by each accredited medical school) being in one separate category (without regard to bed size)".

In the osteopathic profession, there are currently 76 teaching hospitals and nine schools of medicine which are matriculating students. Four of the colleges of osteopathic medicine own their own hospitals. However, the remaining five colleges must choose from among 72 hospitals as to which will be so designated. It is our belief that objective criteria for making this determination should be set forth in the legislation to avoid the potential for arbitrary nominations and to create an equitable selection process. In addition, there should be participation in this process by the hospitals since the decisions being made directly affect the manner and source of a significant portion of their income.

Section 2 does not alter the current appeals mechanism for hospitals participating in the Medicare program. We believe the appeals mechanism provided to those hospitals penalized as a result of the institution falling outside the parameters of the classification system is unrealistic, inequitable, and designed to prevent the hospital from effectively defending itself. It is virtually impossible for a single institution to identify all the hospitals in its classification cell, and then to undertake a proper study to compare and contrast its patient mix, utilization, and cost statistics with all the other hospitals in that cell.

We recommend requiring the institution to provide the rationale for its costs and placing the burden of proof on HEW to show that these costs are unreasonable.

Section 3: Inclusion in reasonable cost of hospital services an allowance for retirement or conversion of underutilized facilities

This Section provides an incentive to close down or convert to approved use underutilized bed capacity or services. Safeguards are to be provided to forestall abuse or speculation, and during the first two years no more than 50 hospitals would be paid these transitional allowances in order to permit full development of these procedures and safeguards. We endorse this proposal, but we take exception to Section 1132(4) (A), the last sentence of which says "any such final determination of the Secretary shall not be subject to judicial review." In spite of the fact that this section is essentially a grant provision, we continue to believe that the recourse of administrative and judicial appeal must be made available.

Section 11: Criteria for determining reasonable charge for physicians' services

We strongly endorse the amendment to Section 1842(b) (3) (3A) (F) (i) which regards any charge for any particular service or procedure performed by a Doctor of Osteopathy or Medicine as a reasonable charge if such service or procedure is performed in a physician-shortage area. We regard such an incentive as an important step toward encouraging physicians to practice in shortage areas.

Section 20: Hospital providers of long-term care services

This Association strongly supports this provision which would make better and more flexible use of underutilized hospital beds in rural areas by providing for a simplified cost reimbursement formula which avoids the current requirement for separate patient placement within the facility and separate cost finding.

This is often referred to as the "swing bed" concept and it is our view that it does indeed create greater and more efficient utilization of underutilized beds in rural areas, particularly where there is a shortage of long-term care facilities. We strongly endorse this proposal but recommend that the benefits of the proposed change be made available to hospitals with up to 100 beds with an average occupancy level of not more than 75 percent instead of the stated levels of 50 beds and 60 percent occupancy in S. 1470.

In a related matter, we find the current three-day hospitalization requirement in Section 1861(i) to be unnecessary and unfair to the patient, and it requires, in some instances, unnecessary utilization of the acute care facilities of the hospital when readmission to an extended care facility would be in the better interests of the patient.

Under present law, a patient can only be admitted to a skilled nursing facility or intermediate care facility, and be covered under Medicare, if he or she has been admitted to a hospital as an inpatient and stays for a period of at least three (3) consecutive days. In addition, if after the patient is admitted to an extended care facility, is treated, and released and it is later determined that re-admission to the facility is warranted, the patient must again be admitted as an inpatient in a hospital for three additional days.

We recommend inclusion in this section of S. 1470 of an amendment to Title XVIII of the Social Security Act, Part C, Section 1861(i), which would strike the words "in which he was an inpatient for not less than three consecutive days before his discharge from the hospital in connection with such transfer". The first sentence of Section 1861(i) would then read as follows: "The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital."

We also recommend that this Subcommittee consider the possibility of drafting a change in the statute which would provide for direct admission to an extended care facility upon proper certification by a physician. Of course, we recognize the need for safeguards to prevent abuse, but we believe the best interests of the patient, the program, and the hospital would be served by such an amendment.

Section 30: Establishment of the health care financing administration

This section would establish a single administration for health care financing headed by an assistant secretary. This provision would result in two assistant secretaries in the health area of the Department of Health, Education, and Welfare, leaving the current assistant secretary for health to deal with policy issue unrelated to the reimbursement area.

The distinguished Chairman of this Subcommittee, Senator Talmadge, has expressed concern about the direction currently being taken by HEW in establishing the Health Care Financing Administration (HCFA). The basis of that concern surrounds the possible placing of many high-level bureaucrats, displaced by other HEW reorganization efforts, in newly-created positions in the HCFA.

It is the view of this Association that Section 30 should remain in S. 1470, until such time as both HEW and the Subcommittee are satisfied that the organization of the Health Care Financing Administration is proceeding in an appropriate manner. It is further our view that this Subcommittee should reconsider the need for the new organization to be headed by an assistant secretary.

The creation of this new position should also include the establishment of a specific and appropriate mechanism to assure coordination of all policy and program implementation decisions. The goals of creating the HCFA are to clarify lines of authority, enhance accountability and assure uniform policy-making.

Such goals can only be achieved if HCFA is organized to assure proper coordination of health care financing issues with other closely related matters such as health planning, peer and utilization review, manpower planning, etc.

Section 31: State medicaid administration

From the point of view of the delivery of health care, and to the extent that the language improves the Medicaid program and saves money, this Association supports Section 31. We are particularly supportive of the incentive approach, both here and in the Medicare program, which rewards hospital efficiency. We have long advocated that the Medicaid program should be federalized and contracted to private insurers for administration. The unevenness of Medicaid benefits and reimbursements among the states can only be leveled through the intervention of the Federal government. The present situation does not consider the critical problems in state financing, and decreases the viability of the existing program and its scope and levels of coverage.

Section 32: Regulations of the secretary

We strongly support the requirement of a minimum period of 60 days for comment on proposed HEW regulations with respect to the Social Security Act. As we have stated in testimony before committees of both the House and Senate, we strongly believe that a formal mechanism for Congressional review of administrative rulemaking is necessary and an overdue reform of current procedures. Extension of the comment period to a minimum of 60 days is one of several recommendations we believe would be a step toward this needed reform.

Section 41: Ambulance service

We commend the Chairman for recognizing the need to cover ambulance service to more distant hospitals where the nearer hospitals do not have a staff member qualified to undertake the care required. This provision rectifies what we believe has been a long-standing problem in which Medicare has been allowed to pay only for ambulance service to the nearest participating institution with adequate facilities.

Section 46: Return on equity

This Section increases the rate of return on net equity of investor-owned (for profit) hospitals and skilled nursing homes from one-and-one-half to two times the average rate of return on Social Security investment. It is our recommendation that this rate be set annually by the Secretary after consideration of the rates of return in industries of comparable risk. This rate of return is approximately 14 percent at the present time and the increase to two times the average rate of return on Social Security investment represents a rate of return of approximately one-half of this rate. We would recommend that this Subcommittee consider an increase to three times the average rate of return, which would be approximately 10-11 percent.

Concluding comments

The ultimate objective of S. 1470 is to provide for permanent reforms in reimbursement under the Medicare and Medicaid programs to provide incentives for the efficient and effective use of our health care resources. This is also a stated objective of the legislation submitted by the Carter Administration, S. 1391.

It is the view of this Association that S. 1391, intended as a stop-gap measure until more permanent reforms can be designed, is both unworkable and inequitable. We have presented testimony to this fact before appropriate committees of the Congress.

The proposed payment system in S. 1470, on the other hand, is based on a classification system of hospitals which provides for a meaningful method to differentiate between efficient and inefficient operations. It recognizes that institutions differ, and that:

There should be allowance for geographic wage differences.

There should be allowance for an equitable exceptions process which recognizes a typical service and patient mix.

There should be exclusion of certain non-comparable and often uncontrollable costs—such as debt services, health manpower training, energy and malpractice—in determining target rates.

There is a need to develop new financial mechanisms that will encourage efficient management of our resources and contain rising costs without, at the same time, impairing the capacity of the health care system to meet patient needs. S. 1470 addresses this issue; S. 1391 does not.

S. 1470 is a reasonable alternative in the development of long-term reforms for the Medicare and Medicaid programs. This bill rewards the efficient institution and penalizes the inefficient; recognizes the major differences between hospitals; prevents reductions in or the elimination of needed services; and assures continued access to services by those in need of them.

The American Osteopathic Hospital Association supports S. 1470, with appropriate amendments as indicated, and we applaud the many months of work and effort that went into drafting and revising what we believe is one of the more equitable reforms of the Medicare and Medicaid programs to date.

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

(Presented by Robert A. Teckemeyer, Associate Executive Director, Professional Relations)

The American Physical Therapy Association (APTA) is the national professional organization of physical therapists. The APTA represents 80 percent of the over 30,000 physical therapists in all 50 states, the District of Columbia, Puerto Rico and the Virgin Islands. Physical therapy services contribute to the rehabilitation and expeditious recovery of patients disabled due to disease or injury, reduce the need for institutional care of the physically handicapped, and permit disabled individuals to achieve the maximum degree of independent living. Such health services are provided to patients in hospitals, long-term care facilities, health maintenance organizations, rehabilitation centers, patients' homes, and in the offices and clinics of physical therapists who are private practitioners.

The APTA is in the forefront of the growing importance and recognition of allied health professionals. The APTA supports Congress and the Administration in their respective efforts to slow the tremendous increase in health care costs, but wishes to stress the importance of legal recognition of allied health fields in any new laws that come out of these efforts. S. 1470 Section 2 (b) amends Section 1861 of the Social Security Act by adding "Criteria for Determining Reasonable Cost of Hospital Services." This new section requires the Secretary of HEW to consult with appropriate national organizations in establishing an accounting and uniform functional cost reporting system and a system of hospital classification.

The APTA wishes to be included in the "appropriate national organizations" consulted. Section (aa) (2) (F) of this new section defines "routine operating costs" as not including "ancillary service costs". While the APTA understands the problems relating to specificity in such definitions, the Association believes that a lack of specificity will cause confusion and unnecessary expenditures that could be avoided by enumerating exactly what costs are controlled by the Section.

The APTA would like to reiterate its objection to the language contained in Section 12(b) (2) of the Bill. The language to be added to Section 1842(b) (3A) of the Social Security Act, by this Section, is virtually identical to the language contained in Section 251(c) of the 1972 Amendments to the Social Security Act. Section 251(c) of the 1972 Amendments limiting Medicare reimbursement for physical therapists to an amount which does not exceed "an amount equal to the salary which would have been paid for the service" if it had been performed in an employment relationship and Section 12(b) (2) of S. 1470 which creates the same reimbursement system for hospital associated physicians do not encourage productivity and efficiency in the delivery of health care services. If physicians in a given area are all limited to the same basic rate regardless of how efficient or productive they may be, there is no incentive to improve or even to maintain the status quo.

The APTA disapproves of the "salary equivalency" language being applied to any health care professional, but is glad to see that physical therapists will no longer be singled out for this ineffective reimbursement method.

The APTA generally approves S. 1470 as a step in the right direction. All health professionals must realize that the time has come for some limiting of the rise of health care costs and the APTA will continue to work with Congress and with HEW to reach an equitable and workable solution to the problem.

STATEMENT SUBMITTED BY THE AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

I. INTRODUCTION

The American Society for Medical Technology (ASMT) is most pleased to provide the members of the Senate Finance Health Subcommittee with our views on S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

ASMT is a national, professional organization composed of over 29,000 members engaged in the delivery of clinical laboratory services. The Society is composed of 50 constituent state societies, in addition to the District of Columbia, which hold charters granted by the national organization. The country is divided into ten regions with an average of five states per region. An elected House of Delegates forms the governing body of the Society and when not in session, its functions are carried out by an elected Board of Directors. The Society is organized to give each member the opportunity to be an active partner in the development of standards and practices enumerated in ASMT's policies, positions, and publications.

Our membership is made up of a variety of nonphysician categories of clinical laboratory personnel including clinical laboratory administrators, supervisors, educators, technologists, technicians, assistants, and such specialists as microbiologists, clinical chemists, hematologists, immunochemists, cytotechnologists, histotechnologists, and nuclear medicine technologists.

Approximately seventy-five percent of our membership hold degrees at or above the baccalaureate level while another ten percent hold associate degrees. The remainder of the membership is composed of individuals who fall in specified categories such as students.

ASMT is vitally concerned with both the areas of accreditation and certification. ASMT cooperated with the American Society of Clinical Pathologists (ASCP) in establishing the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) which is an autonomous agency responsible for the accreditation of education programs for clinical laboratory personnel. Until recently, the Society also participated with ASCP in the certification of clinical laboratory personnel through the ASCP Board of Registry. This past January, however, ASMT endorsed the establishment of an independent certification agency for medical laboratory personnel following the Society's formal withdrawal from the ASCP Board of Registry.

ASMT's rationale for its landmark decision calling for an independent and autonomous credentialing agency was based upon strong professional, public-interest, and legal considerations. In so doing, the Society called for the cooperation of all groups certifying personnel in the laboratory field to participate in establishing and operating an independent and autonomous agency which would directly benefit the entire profession while avoiding some of the current vested interest problems which plague the field.

In addition to a membership diverse in specialty and generalist functions within the laboratory field, laboratory settings or places of employment range from private or independent laboratories to physician offices, clinics, blood banks, research institutes, to hospital laboratories—both governmental and non-governmental. Thousands, in fact the majority, of our active members work in hospital laboratory settings throughout the country.

On behalf of our membership and in the interest of better health care delivery on a national basis, ASMT has previously gone on public record in support of the basic principle that every American should be assured access to quality health care and that no person should be denied health care because of inability to pay.

Although we continue to favor eventual enactment of a well-conceived national health insurance program, ASMT recognizes that the critical problem of controlling the sharp rise in health costs, particularly as they relate to hospitals must receive priority in the Congress.

II. OVERVIEW

The available evidence involving escalating hospital costs suggests a serious national problem requiring careful congressional evaluation in the process of developing an appropriate and long-range cost containment strategy. For example, over the past decade, hospital charges have constituted the single most inflationary bulge in the Consumer Price Index of goods and services. Moreover,

while the cost of living went up 86% between 1960 and 1976, the average cost per patient day skyrocketed 450%—from \$32 to \$175. With hospital charges jumping around 15% a year and the national price tag for hospital care approaching a mind-boggling \$65 billion, it is not surprising that many knowledgeable observers have increasingly sounded the alarm at runaway hospital costs.

Although the current health care system contains acknowledged strengths, an examination of Titles XVIII and XIX clearly points to some serious problems which must be eliminated before a more comprehensive national health plan is implemented. These two programs alone cost taxpayers about \$38 billion in fiscal 1977 and an estimated \$47 billion in fiscal 1978, a staggering increase of \$9 billion in just one year.

Given such startling statistics it would seem unwise to simply build upon our current health care system until some of its fundamental deficiencies can be eliminated. It was for this reason that ASMT testified last year before the Senate Finance Health Subcommittee that the Medicare-Medicaid Administrative and Reimbursement Reform Act offered a significant opportunity to evaluate certain critical administrative and reimbursement issues related to Titles XVIII and XIX. ASMT is pleased to once again commend the initiative of Chairman Talmadge and the various co-sponsors of S. 1470 for reintroducing a revised version of this important legislation during the 95th Congress.

ASMT is pleased to note that some legislative progress has already occurred with respect to several important issues which surfaced during consideration of S. 3205 last year. Namely, Congress has already approved legislation mandating an Office of Inspector General within HEW and is currently considering the Medicare-Medicaid Anti-Fraud and Abuse Amendments. Meanwhile, the recent HEW reorganization created a separate Health Care Financing Administration similar to the one proposed in S. 3205. Since the Society maintains some strong reservations regarding the potential impact of this reorganization on the administration and coordination of HEW's laboratory regulatory program, this issue is discussed in greater depth later in our statement.

Although there are no easy answers to the serious problem of escalating health care costs, particularly within the Medicare and Medicaid programs, the Society is in strong agreement with the basic approach taken in S. 1470 which proposes a long-term solution involving basic structural changes in hospital and practitioner reimbursement under Titles XVIII and XIX. Although fully cognizant of the need to expeditiously develop a national cost containment strategy, ASMT is concerned over legislative initiatives which offer only a transitional approach to the cost issue in the form of an interim cap on hospital revenues. We believe the proposed short-term solution may in fact cause more problems than it actually solves.

The Society is particularly concerned that the cap proposal could result in a restriction on quality hospital care especially for those services traditionally provided by nonphysician personnel. Given the pressure on hospital administrators to stay within the nine percent limit, it is probable that arbitrary personnel reductions in absolute numbers and/or realignments utilizing lesser qualified personnel would occur which could well result in a decline in quality care.

Moreover, the "cap" concept is arbitrary by its very nature and tends to penalize efficient institutions while rewarding those which have tended to be inefficient. Take the case of an institution which may make every attempt to be efficient and keep within the nine percent limit but finds that its costs from certain outside suppliers have doubled or more within a calendar year. Such an institution which had no fat within its budget would have nothing to cut but would still have to pay higher prices imposed from external suppliers. On the other hand, the inefficient institution which had an inflated budget to begin with could reduce unnecessary expenditures to accommodate higher costs for supplies and equipment.

In our estimation, the ideal approach would be to broaden the long-range proposals contained in S. 1470 to reach beyond Medicare and Medicaid and insure that such a program could begin operating at the earliest possible time. ASMT believes that part of the solution to spiraling hospital costs involves developing positive incentives for hospitals such as promoting the closing and conversion of underutilized facilities as proposed in S. 1470. Merely putting a cap on hospital revenues without also applying positive incentives striking at some of the basic structural problems inherent in the current system could well

convert the cap into a floor—an end result which neither the public nor private sector desires. This is particularly important in light of the fact that on any given day an estimated 25% or about 240,000 of the nation's acute care beds are empty.

In this regard, an Institute of Medicine study group last fall concluded that the maximum ratio of short-stay beds to population should be four per 1,000 and recommended that some 90,000 beds would have to be closed in order to achieve that goal by 1981.

As the Congress considers both the pros and cons of the various cost containment proposals ASMT respectfully recommends that the following important areas receive additional emphasis in the development of a long-range strategy:

1. More effective utilization of nonphysician health practitioners.
2. Increased emphasis on out-patient care.
3. Greater reliance on pre-admission testing which, according to the Blue Cross, has cut patient stays from one to two days.
4. Greater utilization of home health care services.
5. Additional public and private support for consumer health education including greater emphasis on good health practices along with a more intensive commitment to preventive health care.

At this point, the Society would like to concentrate the remainder of its comments and recommendations on specific sections of S. 1470 which are of particular interest to our profession.

III. HOSPITAL-ASSOCIATED PHYSICIANS

In evaluating Federal reimbursement practices, ASMT is convinced that the large majority of hospital-based physician specialists do not intentionally abuse the current system. It appears to us that the real issue in need of resolution concerns the relative merit of the present reimbursement process itself.

ASMT supports the development of a reimbursement system which is based solely upon the personal professional effort and amount of time spent by practitioners in the performance of specified functions. In this regard, the Society believes it is extremely important to examine the actual functions and roles performed by hospital-based personnel.

Section 12 of S. 1470 would amend the Social Security Act by distinguishing between physicians' services of an educational, executive or research nature and those personally performed or directed for the benefit of a patient and which are customary and appropriate. The latter services would be allowable on a fee-for-service basis while the former would be allowed through reasonable overall compensation related to the time and effort spent by the physician in the performance of the specified services.

A special definition would be applicable to pathology services which defines "physician services" to exclude services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operation customarily performed by nonphysician personnel. In this regard, ASMT is able to provide the Subcommittee with some background information reflecting the scope of duties which are presently performed by nonphysician personnel in the clinical laboratory.

For illustrative purposes, let us focus on medical technologists who possess a broad background in basic and applied clinical sciences and perform four major roles within the hospital laboratory setting. Primarily, the medical technologist performs the diagnostic testing procedures essential to the diagnosis, treatment and maintenance of a patient's medical condition. In addition to repetitive testing across a broad range of laboratory procedures, medical technologists also perform complex testing in a variety of specialized areas such as microbiology, parasitology, serology, hematology, clinical chemistry, urinalysis, and immunohematology.

Secondly, technologists fulfill the duties and responsibilities of technical supervisors, in both the generalist and departmental/section areas. Thirdly, the Chief or Administrative Technologist assumes a variety of managerial responsibilities within the hospital laboratory. Finally, the medical technologist also plays a direct and primary role in the educational process of clinical laboratory personnel.

As an indication of the degree of nonphysician involvement in clinical laboratory operations, ASMT testified during hearings held last year on S. 3205 providing detailed information relative to the supervisory, administrative and

educational functions performed by the medical technologist. Since we believe this topic is of such fundamental importance in understanding reimbursement issues related to hospital-based clinical laboratories, the Society appreciates the opportunity to once again provide this information for the Committee's consideration.

Role of the medical technologist in laboratory supervision.—In the majority of hospitals, medical technologists have traditionally served as technical supervisors of the total laboratory as well as technical supervisors of designated, specialty departments/section areas. Supervisors usually work under the direction and in cooperation with the administrative technologists or chief technologist.

Supervisors plan, organize and delineate the duties and responsibilities of personnel working under their direction. They assume the responsibility of instigating new procedures and establishing and maintaining quality control programs. They train personnel, maintain supplies and disseminate information from their department to other members of the laboratory staff. They also maintain procedural directions and ascertain the reliability of test results issued from their departments. Supervisors are also responsible for responding to inquiries concerning their departments.

Medical technologists are unquestionably involved in supervising the planning, processing and reporting of laboratory tests. The degree of involvement depends upon the organizational structure of the institution. In the smaller hospitals, the supervisor's duties are all inclusive and even in the largest medical complex the medical technologist maintains supervisory responsibilities of departments within the laboratory. These nonphysician functions are commonly established and accepted by hospital administrations.

Role of the Chief or administrative technologist in laboratory management.—On December 30, 1975, ASMT issued a Report on a Laboratory Management Survey to document which administrative functions are carried out by the medical technologist holding an administrative level position in the clinical laboratory. The survey was directed and conducted by the Personal and Professional Development Division of ASMT in the fall of 1975. The respondents to the survey totaled 1,292 ASMT members who hold the position of Administrative Technologist or Chief Technologist, with the nationwide distribution of the survey population representing various places of employment, size of institution, geographical regions, and urban and rural settings. A copy of the complete study including statistical analyses has previously been provided to the Committee and the staff.

The study disclosed that according to distribution by place of employment, 61 percent of the respondents were employed in hospitals. Thirteen percent of these were located in 1-99 bed hospitals; 26 percent in 100-299 bed hospitals; and 22 percent in hospitals of 300 or more beds.

Given the expansion of health care services over the past decade, and the associated changes within the medical laboratory, which include increased testing, technological improvements, and changes in roles and functions of certain personnel, the study sought to determine the degree of involvement of medical technologists in the critical areas of management and supervision. The ASMT laboratory management survey clearly indicates that medical technologists are now playing a central role in laboratory management. In fact, according to these data, the administrative medical technologist carries out a majority of the laboratory's administrative functions.

Thirty-three administrative functions common to the medical laboratory were listed on the survey questionnaire. The functions listed ranged from who "interviews prospective employees," to who "evaluates electronic data programs and reports." To aid in reporting the survey results, the functions were separated into three categories of Personnel Management; Clinical Services Management; and General Laboratory Management. Table 1 lists the administrative functions, as categorized.

Five choices of who carries out the functions were available on the questionnaire, consisting of:

(1) Administrative Technologists, Chief Technologist, or Laboratory Manager.

(2) Administrative Technologist and Director of Laboratories—joint function.

- (3) Director of Laboratories.
- (4) Does not apply to my situation.
- (5) Other (please specify).

The report summarizes functions carried out by four groups in the medical laboratory and this information may be found in Table II.

In sum, the 1,292 medical technologist respondents report that they carry out, on an average, 17.6 or a majority of the 33 listed administrative functions. They report that the Directors of Laboratories on an average, carry out 2.6 of the 33 functions; the medical technologist and director jointly carry out an average of 7.9 functions; and hospital administrators carry out 1.8 functions.

Thus, for the 1,292 questionnaires analyzed, Chief and Administrative medical technologists have a significant involvement in a wide range of the administrative functions performed in the medical laboratory. While the respondents' involvement ranges from an average of 88 percent who "schedule laboratory personnel" to 20 percent who "establish charges for laboratory tests," the responses are remarkably consistent across the major categories of places of employment and the ten geographical regions.

Medical technologists employed in hospitals with less than 300 beds have the highest average direct involvement in the functions of "reviewing and approving new laboratory methodologies"; "selecting the appropriate testing program"; "maintaining laboratory systems"; and "selection of equipment to purchase" for all grouped places of employment. Their average direct involvement for all listed functions in hospitals of 1-99 beds is 61 percent while the average for all places of employment categories is 54 percent.

Role of the medical technologist in medical technology education.—While the essentials for Medical Technology Programs prepared by the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS), require sharing of responsibility between the medical director and the medical technologist program director for the organization and administration of the program, the guidelines outline the medical technologist's duties as follows:

"6. Duties of the program director: In consultation with the medical director, education coordinator and senior faculty he should be responsible for overall direction of the program. With the assistance of appropriate committees he should provide leadership in development and implementation of:

1. program objectives
2. admission policies
3. curriculum development
4. evaluation procedures
5. promotion of students
6. recruitment
7. public relations (including preparation of catalogues and brochures relating to the program).

He should maintain student records and participate in the student services such as counseling and recruitment. He should attend at least one workshop or one course related to education each year."

It can be seen, therefore, that the medical technologist plays the primary role in the medical technology educational process. Moreover, it should be noted that significant educational activity occurs within the hospital. For example, the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) indicates that as of May 21, 1976, the approved medical technology student capacity stood at 7,736 in over 650 AMA accredited hospital programs. This compares with a student capacity of approximately 1,856 in university-based medical technology programs. The medical technologist, usually entitled an Educational Coordinator in the hospital setting, is in reality if not in title, in most instances, the individual most directly responsible for the education of medical technology personnel within the hospital. In fact, as the information in Table IV demonstrates, the medical technologist is involved in the overwhelming majority of the nineteen roles listed for the medical technology education program. This table is based upon review of the duties and responsibilities of a representative sample of medical technology education coordinators. For certain roles, it will be noted that both the physician and the medical technologist are jointly involved while there are few roles performed exclusively by physician personnel.

TABLE I.—CLINICAL LABORATORY ADMINISTRATIVE FUNCTIONS

Personnel management functions	Clinical services management functions	General laboratory management functions
Schedules laboratory personnel.....	Selects and authorizes expendable supplies.....	Prepared statistical reports for laboratory.
Counseling of personnel.....	Authorizes reagent purchases.....	Prepares or selects laboratory report forms.
Provides in-service orientation.....	Maintains a laboratory safety program.....	Administers the laboratory budget.
Interviews prospective employees.....	Selection of equipment for purchases.....	Prepares the laboratory budget.
Conducts regular personnel meetings.....	Maintains preventive maintenance program.....	Determines laboratory space allocation.
Determines merit or salary increases.....	Authorizes equipment purchases.....	Established charges for laboratory testing.
Determines personnel policies in accordance with employer policies.....	Selects appropriate proficiency testing program for use.....	Represents laboratory in inter- and/or intra-departmental operations.
Determines base salary level for employees when they are hired.....	Reviews and approves new methodologies (techniques and/or tests).....	Maintains laboratory cost accounting and cost analysis program.
Conducts performance evaluation sessions with employees.....	.....	Evaluates electronic data programs and reports.
Determines academic and experience qualifications for each position.....	.....	.....
Selects qualified prospective employees.....	.....	.....
Authority to fire employees.....	.....	.....
Determines employees' promotions.....	.....	.....
Determines academic and experience qualifications for each position.....	.....	.....

TABLE II.—SUMMARY OF THE FUNCTIONS CARRIED OUT BY 4 GROUPS IN THE MEDICAL LABORATORY
[In percent]

	Personnel management	Clinical services management	General laboratory management
Medical technologists (respondent).....	57	55	47
Director of laboratories.....	7	9	8
Joint function of technologist and director.....	23	26	24
Does not apply.....	4	2	10
Hospital administrator.....	5	4	7

	Medical technologist only	Physicians only	Medical technologist/physicians
1. Development/review of curriculum.....	×	-----	×
2. Development of criteria for student selection.....	×	-----	×
3. Selection of students according to criteria.....	×	-----	×
4. Development of program philosophy, goals and policies.....	×	-----	×
5. Provision for medical relevance.....	×	-----	×
6. Provides general orientation to multiple facets of the profession such as: Medical ethics; legal liabilities; relationship to patient and health professionals, etc.	×	-----	×
7. Development of educational objectives and determination of acceptable levels of competence for all areas.	×	-----	-----
8. Development and implementation of all necessary schedules and rotation for attainment of educational objectives.	×	-----	-----
9. Schedules and supervises lectures, lecture content and practicum activities necessary for attainment of educational objectives.	×	-----	-----
10. Development, review and evaluation of oral, written, and practical examinations for use in determining student performance.	×	-----	×
11. Evaluation of student's progress toward attainment of educational objectives.	×	-----	-----
12. Counsel students in various areas: Career choice, performance, attitude, etc.	×	-----	×
13. Teaching (lectures and/or practical): (a) Students; (b) Peers; (c) Faculty; (d) Physicians, interns and residents.	×	-----	×
14. Development of cooperative activities between affiliated academic and clinical facilities, including service on designated committees.	×	-----	×
15. Answering written and oral inquiries related to the educational program.	×	-----	-----
16. Maintaining continuing competence in educational principles and practices and/or in specific technical area(s).	×	-----	×
17. Preparation of budget(s) for educational program.....	×	-----	×
18. Employment of personnel to be involved in educational program.....	×	×	×
19. Procurement of external funds for educational programs (writing of grants for Federal, State, and private support).	×	×	×

Note: When medical technologist only and medical technologist/physician both are checked, this reflects the variety of approaches which are in practice within existing educational programs. This is due to the variance of educational programs and their administrative structure.

IV. ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

Section 30 of S. 1470 proposes the establishment within the Department of Health, Education, and Welfare of a separate organizational unit to be known as the Health Care Financing Administration. This unit, under the direction of a new Assistant Secretary for Health Care Financing, would include the functions of the Bureau of Health Insurance (BHI), the Medical Services Administration (MSA), the Bureau of Quality Assurance (BQA), and the Office of Nursing Home Affairs (ONHA). In our testimony last year we acknowledged that in order to effectively reform the existing administrative and reimbursement authority of the Medicare/Medicaid programs, some reorganization within the Department is mandatory in order to provide a sturdy foundation upon which to build any future structure of national health insurance.

While the Society still maintains this position, we must be frank in stating to the Committee that neither the proposed reorganization required by S. 1470 nor that already put into effect by Secretary Califano is capable, in our considered opinion, of resolving some of the most serious administrative and management problems existing within HEW. ASMT must continue to question the advisability of further splintering HEW's health, health financing and its quality assurance agencies under separate administrative structures.

In recent years, bureaucratic disputes between the Social Security Administration and the Assistant Secretary for Health have been frequent and disruptive of effective health policy making. The HEW reorganization has merely switched some of the players around but the same ballgame will likely be played: more bureaucratic infighting and jockeying for a favored position with the Secretary.

If anything, we believe the new HEW organization may ultimately create a greater variety of jurisdictional disputes between competing components of the Department even with a "strong" Secretary cracking the whip. In our opinion, the health responsibilities of HEW are so numerous, interrelated and complex that the only effective bureaucratic plan is to strengthen the structural relationships between the health, quality assurance and financing programs of the Department. Unfortunately, neither the legislative solution proposed nor the plan already put into effect by the Administration satisfies this critical requirement. The only way to enhance a bureaucratic environment capable of supporting a superstructure which can provide rational and effective health policy decisions at the Federal level is by having a single Assistant Secretary for Health accountable to the Secretary for *all* health and related financial programs. Ultimately, ASMT envisions a Cabinet-level Department as the logical outcome of such a merger. While the political environment may not be ready to accommodate such a drastic departure, we believe that such reorganization becomes largely inevitable under a national health program.

The record of HEW's administration of its laboratory regulatory responsibilities provides a vivid example of the serious problems attendant when multiple agencies, each holding different philosophies and accountable to competing bureaucratic components attempt to "coordinate" their differences. In fact, the laboratory case history is so notorious that it has, in essence, become a "living legend" within the HEW bureaucracy.

The performance record shows that HEW, which is charged with administering the 1967 Clinical Laboratory Improvement Act and the participation of laboratories under Medicare, has been continuously hampered in regulating the work of clinical laboratories by self-acknowledged jurisdictional disputes between involved agencies. The true source of these problems has been the lack of top management accountability in HEW for coordination of its laboratory-related responsibilities.

One dramatic example is when a bureaucratic impasse effectively held up final publication of the Medicare independent laboratory regulations until September 14, 1974, more than two years from the date they were originally proposed. In an effort to rectify the situation and to respond to proposed legislation, the three agencies previously responsible for clinical laboratory administration¹ developed and signed an agreement in 1975 intended to delineate and clarify the functions of each agency with respect to the Department's laboratory programs.

¹ The Bureau of Health Insurance (BHI) of the Social Security Administration (SSA), the Bureau of Quality Assurance (BQA) of the Health Services Administration (HSA), and the Center for Disease Control (CDC).

But, no sooner than signed, discrepancy erupted between the Public Health Service and the Social Security Administration over divergent interpretations of certain personnel qualifications under the Medicare program. This confusion between these two agencies was finally resolved but not before the Assistant Secretary for Health was drawn into the dispute.

More recently, the commitment of HEW to develop personnel standards applicable to both independent and hospital laboratory settings has been seriously delayed by the inability of the three agencies to agree. Former Assistant Secretary for Health Dr. Theodore Cooper had to once again intervene but this occurred too late to effect any final agreement before the change in Administration.

Simultaneously, a memorandum issued by former CDC Director Dr. David Sencer to the acting HEW Assistant Secretary for Health James F. Dickson recommended that the Interagency Agreement for the regulation of clinical laboratories not be implemented further. Sencer stated, " * * further attempts to implement this agreement, or to delegate to BHI the responsibility for applying national standards for interstate laboratories through the state agency system, will result in unacceptable degradation in the quality of services now required under the Clinical Laboratories Improvement Act of 1967 (CLIA 1967). This is evidenced by the plans and actions taken by BHI in the last few months, which have been in direct conflict with the advice and positions of CDC with respect to both new and old regulations and interpretations."

CDC not only recommended against further implementation of the Agreement, but promised to "publicly demonstrate the degree to which the State agency system is failing to apply appropriate and applicable standards * * *" if their recommendation is ignored.

Since that time several additional "agreements" tentatively have been worked out by HCFA and PHS officials with the latest draft copy included as Attachment A to this statement. This draft agreement serves to illustrate the inherent weakness in any "inter-agency" understanding which is open to varying interpretations. While all sides may honestly strive to coordinate regulatory responsibilities, varying philosophies and allegiances often result in policy disputes which are finally resolved at the Secretarial level but only at a disservice to the public because of the unreasonable delay in policy resolution.

Although little time has elapsed since the most recent HEW reorganization, what we have seen to date does not encourage ASMT to believe that without the benefit of stronger structural linkages than now exist the new HEW regime will be any more successful in effectively administering the Department's laboratory responsibilities than its predecessors.

V. TERMINATION OF HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

Section 33 of S. 1470 proposes to terminate the Health Insurance Benefits Advisory Council (HIBAC). Initially conceived by its advocates as an important and influential source of private sector advice and input to the Medicare program, HIBAC was established under Title XVIII of Public Law 89-97 in July, 1965. The chief responsibility of this advisory group has been to advise the Secretary of HEW on matters of general policy in the administration and development of regulations under this Title.

The Council, which is composed of various leaders in the health field and the general public has provided professional input on over 100 policy issues under Title XVIII. These issues have ranged from extended care facilities, home health agencies, independent laboratories, the principles of reimbursement for provider costs and for physician services, as well as policies governing physicians' certification and recertification of the need for medical services.

ASMT firmly believes that while HIBAC has been criticized as being largely ineffective, especially in recent years, the fault does not rest with the concept itself but rather with the inappropriate utilization of the advisory body by HEW. Although neither HIBAC nor most other health advisory groups actually make final program decisions themselves, such mechanisms should ideally provide valuable input to both the Secretary and the Congress on what actions they believe need to be taken based upon their members' recommendations; members who bring to each group specialized backgrounds and expertise in various areas of the health field including consumer input.

Recognizing that the regulations necessary to implement legislation such as S. 1470 will be far-reaching and will directly affect the delivery of health services under Medicare/Medicaid programs as well as those professionals who pro-

vide these services, ASMT is concerned that abolishing HIBAC without establishing an alternative advisory mechanism would obviate formal and direct private sector input with regard to drafting revised regulations for Titles XVIII and XIX of the Social Security Act. Although the elimination of HIBAC is in keeping with the Administration's announced policy of cutting back on Federal advisory committees, we do not believe such a policy is in the best interests of either the public or the various health professions who serve it.

Our Society is most concerned with the prevailing Administration attitude, which is confirmed by this provision in S. 1470, that formal advisory mechanisms which allow for professional input within governmental decision-making processes are not effective. Although a thorough review of all advisory committees is certainly indicated and elimination of those which serve no useful purpose should be encouraged, evidence to date is largely indicative of a "numbers game"—how many such groups can be terminated.

ASMT suspects that a careful evaluation of the advisory committee process would most likely demonstrate a strong case in favor of continuing most groups *but* changing the traditional manner in which committee members are selected. Perhaps if we moved away from selecting individuals representing the "old boy network" and emphasized instead a variety of interests including the nontraditional, in the selection process, the government might utilize such groups more effectively. Since under the Federal Advisory Committee Act, formal advisory committees are usually the only legal entry for multiple individuals to participate in policy discussions with government officials, ASMT believes that instead of eliminating such mechanisms they should be strengthened and made more representative of broad based public interests.

In summary, the Society believes that an appropriate advisory council could and should play a useful and important role as a provider of necessary professional and consumer advice and information to the HEW administrative unit responsible for drafting regulations and implementing standards promulgated

ATTACHMENT A

GENERAL STATEMENT—CLINICAL LABORATORIES—HEALTH AND HCFA

The locus of responsibility for surveying and certifying laboratories will reside in HCFA. The lead responsibility in developing technical and scientific laboratory standards will rest with the Center for Disease Control (CDC) endorsed by ASH, subject to approval by HCFA. In turn, HCFA can also initiate such standards for consideration and approval of CDC. Differences of opinion shall be resolved promptly by the Administrator of HCFA and the ASH. Unresolved differences shall be adjudicated by the Secretary. HCFA will coordinate and promulgate standards.

CDC shall continue to provide strong technical and scientific consultative service to clinical laboratories (including proficiency testing) throughout the country. CDC may be asked for technical assistance by HCFA survey staff. CDC may also monitor periodically the performance of survey and certifying bodies and report its findings to ASH and the HCFA Administrator.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

In response to the proposed "Medicare-Medicaid Administrative and Reimbursement Reform Act", the American Society for Medical Technology:

Endorses the intent of the legislation towards Medicare/Medicaid reform through reorganization within the Department of Health, Education, and Welfare and through basic structural changes in hospital and practitioner reimbursement under Titles XVIII and XIX.

Recommends amending the legislation to organizationally place the proposed Health Care Financing Administration under the authority of a single Assistant Secretary for Health within HEW.

Supports Federal reimbursement mechanisms which fairly compensate personnel based upon their personal professional effort and amount of time spent in the performance of specified functions.

Opposes the abolishment of the Health Insurance Benefits Advisory Council without establishing an alternative advisory mechanism as a conduit for formal and direct input from the private sector.

Believes the ideal approach would be to broaden the long-range proposals contained in S. 1470 to reach beyond Medicare and Medicaid and insure initiation of the program at the earliest possible date.

Recommends that consideration be given to the following areas in the development of long-range cost-containment strategy:

1. More effective utilization of non-physician health practitioners.
2. Increased emphasis on out-patient care.
3. Greater reliance on pre-admission testing which, according to the Blue Cross, has cut patient stays from one to two days.
4. Greater utilization of home health care services.
5. Additional public and private support for consumer health education including greater emphasis on good health practices along with a more intensive commitment to preventive health care.

STATEMENT OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

The American Society of Clinical Pathologists appreciates the opportunity to submit the following comments on S. 1470, "The Medicare-Medicaid Administrative and Reimbursement Reform Act".

The American Society of Clinical Pathologists is a non-profit, educational and scientific medical specialty society, representing nearly 23,000 medical laboratory professionals, including approximately 6,500 Board-certified pathologists. Because of this vital involvement in the health care system of this nation, we are, of course, concerned with the federal reimbursement programs, Medicare and Medicaid. We commend Senator Talmadge and the members of the Committee for their work on this complex reform legislation.

We would like to confine our comments on S. 1470 to the sections of the bill which relate to reimbursement for physician's services: Sections 12 and 15.

SECTION 12: HOSPITAL-ASSOCIATED PHYSICIANS

Section 12 of S. 1470, which outlines reimbursement policies for hospital-associated physicians, defines such services by excluding services performed "as an educator, an executive, or a researcher; or any professional patient care service unless the service (A) is personally performed by or personally directed by a physician for the benefit of the patient and (B) is of such a nature that its performance by a physician is customary and appropriate".

Further, the bill defines "pathology services" as follows:

Pathology services shall be considered "physicians' services" to patients only where the physician personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. These include operating room and clinical consultations, the required interpretation of the significance of any material or data derived from a human being, the aspiration or removal of marrow or other materials, and the administration of test materials or isotopes. Such professional services shall not include professional services such as: the performance of autopsies; and services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operations that are customarily performed by nonphysician personnel.

These definitions of services performed by physicians, and more specifically, pathologists, do not take into consideration the *physician component* which is a factor in all of laboratory medicine. We suggest that the language in Section 12(a) (2), 3 be deleted, and we support the inclusion of the following, in lieu of that language:

(3) Pathology services shall be considered physicians' services where the physician performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. Exercise of this medical judgement includes operating room and clinical consultations, the interpretation of the significance of examination of any material or data derived from a human being, the aspiration or removal of marrow or other materials, the administration of test materials or isotopes, the performance of autopsies, and services performed in carrying out medical responsibilities for supervision, quality control, and the other aspects of a clinical laboratory's operations.

It is vitally important that a clear understanding be established as to the variety of services rendered by physicians throughout the spectrum of the health care system. Only then can a proper method be established for reimbursement for these services. We submit the following examples of the complexity of the physician's role.

Physicians as managers

In the next twenty years it will almost certainly have been learned that the managerial role of the physician cannot any longer either be bypassed by health care planners or ignored by physicians, since the practicing physician in any system of health care is and will continue to be the key decision-maker in the use of services, equipment and facilities. This critical decision-making function in actual day-to-day practice necessitates physician involvement in many managerial functions, such as planning, development of services, cost control, quality assurance (including over and under-utilization of services), and even operations such as surgical procedures. As health care delivery systems become increasingly complex, and they inevitably will, the managerial role of physicians will become correspondingly more important and more widely recognized. Management skills will be needed by physicians together with greater understanding of the organizational dynamics of working with other autonomous professionals and team operators. This is already underway. New professional skills are being developed which will become formalized, and physicians will be far more effective participants in the management operations of health care programs assistance than is the case today.

Automation and programmed health care services

Automation and programmed services of various kinds will play a prominent role in health care in the future. There is general agreement that computer banks will be used to store patient care data for both mobile and immobile populations. Information will be available on an on-line basis, with telephone access from distant offices, hospitals or patient bedsides. Disease detection and diagnosis will be aided by such things as automated screening systems, computer-assisted histories, paramedical physical examinations, multi-channel auto-analysis, implanted monitoring of body systems, already available telemetry of various kinds and computer-assisted diagnosis.

Since all of this will necessarily be under the supervision of physicians and used by physicians, considerable technological knowledge will be required of the physician. Automation and programmed assistance will be expected to free the physician's time and extend his reach and thus enable the professional to provide more services to more people. Whether personalization of health care will improve or deteriorate under these conditions of practice remains to be seen.

SECTION 15: USE OF APPROVED RELATIVE VALUE SCHEDULE

Section 15 of S. 1470 provides for the establishment of a system of relative value scheduled for medical services. The American Society of Clinical Pathologists support the establishment of such a system.

Our Society supports the concept of multiple options for compensation arrangements. We view the relative value schedule as a viable option, along with direct billing, and lease arrangements.

We also strongly support the inclusion of a physician component in a relative value schedule for pathology services. The physician component varies in each laboratory service, and is determined separately for each item. It is that part of the service or procedure which requires the pathologist's professional participation—ranging from his maintaining of high standards in the laboratory, to his actual interpretation and diagnosis. We believe that a relative value schedule must include a provision for the physician component.

We support the amending of Section 15, Subsection (b), to include the following:

“(b) Upon development of a proposed system of procedural terminology and its approval by the Secretary of Health, Education and Welfare, it shall be published in the Federal Register. Interested parties shall have not less than six months in which to comment on the proposed system and to recommend relative values to the Secretary for the procedures and services designated by the terms. *In the instance of hospital-associated pathologists' procedures and services, such relative value schedules shall include*

physician components for each clinical pathology laboratory procedure. Comments and proposals shall be supported by information and documentation specified by the Secretary."

This addition to the language of S. 1470 properly reflects the pathologist's role in laboratory services.

We thank the members of the Health Subcommittee for this opportunity to comment on certain provisions of S. 1470.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE, SUBMITTED BY WILLIAM P. DAINES, M.D.

SECTION 2—CRITERIA FOR DETERMINING COST OF HOSPITAL SERVICES

This section would establish an incentive system for reimbursing hospitals' "routine operating costs" under federal health programs. Hospitals would be classified according to bed size, type, and other criteria; cost would be determined for each classification through a uniform accounting and reporting system; and a per diem rate for routine operating costs would be determined for each hospital.

The American Society of Internal Medicine believes it is important to promote hospital efficiency and contain costs and that this approach is the best yet proposed by Congress. Its most desirable features are the positive incentives for efficiency and its recognition of the differences in individual hospitals.

We do have some concerns about administration of the program but will not detail them at this time. To provide the desired flexibility for dealing with individual institutions, the program must necessarily be complex. If it is enacted the development of regulations and their implementation will be critical to its success and we sincerely hope the Secretary of HEW will be responsive to input from the private sector during the process.

We are pleased that the program would be implemented "for informational purposes" in 1979 but not become effective until fiscal year 1981. This time is necessary to develop an acceptable hospital classification system and administrative capacity to implement the program and to allow hospitals to adjust to the change in reimbursement methods. We believe this time should also be used by HEW to conduct trails and report to Congress on the programs' expected impact before it becomes effective. Although similar reimbursement systems have been tried on a limited basis before, the results have been both good and bad. This particular model would be applied for the first time nationwide, and careful evaluation prior to implementation will be critical.

SECTION 3—PAYMENT TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

This section would provide for reimbursing certain classifications of hospitals for capital and increased operation costs associated with closing down or conversion to approved use of underutilized bed capacity or services. ASIM supports this section.

SECTION 10—AGREEMENTS OF PHYSICIANS TO ACCEPT ASSIGNMENT OF CLAIMS

In the version of the bill introduced last year, non-participating physicians would not have been allowed to accept assignment on any patients. We objected to this strongly and commend its elimination from the current proposal. However, we oppose offering increased incentives only to a category of participating physicians. First, the differential between Medicare payment and physician charges is so great that we don't think the incentives identified would convince many physicians to accept assignment on all patients and thereby give up their right to bill patients directly. Second, if the objective is to save administrative time and cost by increasing acceptance of assignment, we believe offering incentives to all physicians to accept assignment on their patients would accomplish more.

For example, if it is cost effective to offer the multiple billing option to encourage assignment, it should be offered to all physicians who have assignment patients. If as we suspect, multiple billing would save tax payers money by itself, regardless of whether assignment is accepted or not, then we believe all physicians should be allowed to submit multiple claims for all Medicare patients.

The one dollar "administrative cost savings allowance" is arbitrary and its effect would vary from physician to physician. For example, for physicians who see relatively few patients the one dollar would provide little incentive. For all physicians this amount is insignificant when compared to the differential in reimbursement between acceptance and non-acceptance of assignment. Adoption of this provision would probably be beneficial to low quality, high volume type practices that specialize in Medicare patients in order to capitalize on the one dollar per patient incentive. Although a very small minority of physicians are likely to be involved in such practices, the result could be inferior care to its significant number of Medicare patients.

SECTION 11—CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIAN SERVICES

This section of the bill would add an additional limitation on the determination of reasonable charges for physician services under Medicare. The Secretary would be required to determine statewide prevailing charge levels for each state. The statewide prevailing charge level would be set at the 50th percentile of the customary charges made for similar services by all physicians in the state. No local prevailing charge levels would be permitted to exceed the statewide level by more than one-third.

The intent of the original Medicare legislation was to reimburse beneficiaries based on the usual, customary, and reasonable (UCR) concept. Subsequent amendments and regulations eroded and distorted the original UCR concept and have caused a widening disparity between program reimbursement and physician charges. This accounts for most of the increased out-of-pocket expenditures by beneficiaries and the declining rate of assignment acceptance by physicians.

Imposition of a statewide prevailing charge level called for in this section may further increase this disparity. While ASIM concurs with the goal of attracting more physicians into rural areas, it does not believe restricting differentials between patients of urban and rural physicians in this manner will accomplish this goal. Curtailment of patient reimbursement for the services of urban physicians is more likely to result than movement of physicians into rural areas. ASIM recommends that this provision be deleted.

SECTION 12—HOSPITAL-ASSOCIATED PHYSICIANS

This section, although titled "Hospital-Associated Physicians", would establish a new definition for all reimbursable physician services under the Medicare program. The definition of "physician services" would exclude services performed as an educator, an administrator or a researcher, and would exclude any patient care service unless such service was 1) personally performed or personally directed by a physician for the benefit of such patient and 2) is of such a nature that the performance by a physician is customary and appropriate.

ASIM objects to this definition of what constitutes physician services. Physicians should be reimbursed under Medicare for services which are recognized as appropriate medical practice within their state. The proposed definition is vague and would be subject to regulatory interpretation that could further limit services reimbursable under Medicare.

SECTION 14—PAYMENTS ON BEHALF OF DECEASED INDIVIDUALS

ASIM supports this provision to provide greater flexibility for survivors of deceased beneficiaries in obtaining payment for services rendered to the beneficiary under the Medicare program.

SECTION 15—USE OF APPROVED RELATIVE VALUE SCHEDULE

This section would direct the Secretary of HEW to establish a system for defining medical services and procedures under Medicare Part B. This system and a corresponding set of relative values would be developed by the Health Care Financing Administration (HCFA) with the advice of professional groups and other interested parties.

ASIM strongly opposes development of a new system of terminology by HEW and cannot support the bill if this provision is included.

For a procedural terminology system to be meaningful and equitable, we believe it must accurately describe the way medicine is actually being practiced. Such a system exists in "Current Procedural Terminology, Fourth Edition" (CPT IV). We support its adoption as a nationwide uniform system to define physician services and procedures.

We believe the medical profession is in the best position to describe what it does most accurately. The American Medical Association, with the active participation of ASIM and other specialty societies, has worked long and hard since 1960 to develop precise definitions of medical services and a corresponding coding system. First published in 1966 CPT is more widely accepted than any other system. Its use is endorsed by the Health Insurance Association of America, 36 state medical associations, and 16 national specialty societies. CPT has been adopted as the preferred system for the CHAMPUS program and is accepted under Medicare and Medicaid.

The major criticism of CPT has been its infrequent updating. With the recent publication of CPT IV, a mechanism for systematic and continuing review and updating has been established. This will insure the timely inclusion of new procedures of proven clinical value as well as the elimination of outdated procedures. Directing HEW to develop another system would require the expenditure of unnecessary effort and government funds.

Past discussions with HEW officials about development of a procedural terminology system for Medicare have indicated their inclination to compromise accuracy for administrative and cost consideration.

HEW has suggested (*Federal Register*, May 27, 1975) adoption of a terminology system that would describe services in terms of the time they take as well as other factors. ASIM had objected to using time as a descriptor for the following reasons: 1) If time is used other more meaningful descriptors would be ignored. 2) Time is an inaccurate and often misleading measure of medical service. It fails to take into consideration differences in the complexity of illnesses, competence and proficiency of physicians, practice environment, and patient population. For example, a system describing medical services in terms of time would fail to distinguish between the value of the time spent by an internist with a 65-year-old patient with coronary disease complicated by diabetes and the time spent by a physician seeing an otherwise healthy adolescent with a sore throat. 3) Describing services (and paying for them) according to the time they take can reward inefficiency and thereby increase costs.

In spite of these arguments HEW has continued to support time as a descriptor of medical services for administrative reasons.

Although section 15 directs the HCFA to seek the advice of professional groups in developing this system, we don't believe that this will assure accurate descriptions. A system without accurate descriptions is counterproductive and unacceptable to the medical profession. Further, this section gives no recognition to the substantial efforts of the medical profession to develop a procedural terminology system. ASIM therefore recommends that this section be amended to provide for the use of the most current edition of CPT under all federal health insurance programs or be completely deleted.

SECTION 23—VISITS AWAY FROM INSTITUTIONS BY PATIENTS TO SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

This section allows a Medicare patient in a skilled nursing facility or in an intermediate care facility to make visits outside the institution without such visits being regarded as indicating conclusively that the patient is not in need of the facilities' services. This is highly commendable. If more regulations which affect patient care were similarly flexible to allow application on an individual patient basis, physicians would find federal health programs much less objectionable.

SECTION 33—REPEAL OF SECTION 1867

Repeal of this section would abolish the Health Insurance Benefits Advisory Council (HIBAC). The stated reason for discontinuing HIBAC is that it is no longer significant in policy development for Medicare and Medicaid. What has not been stated is the reason—HIBAC has been denied the opportunity to play a significant role. Initially, HIBAC served as a valuable advisory group. But as the programs evolved, bureaucratic policy direction appears to have replaced

outside advice. Non-governmental input into federal policy making is an integral part of our democratic process. We strongly recommend that HIBAC be continued and assigned a meaningful advisory function.

SECTION 41—AMBULANCE SERVICE

This section would provide Medicare coverage for ambulatory service to hospitals other than the nearest hospital if the nearest is not adequately equipped and staffed to provide the necessary treatment. This solves only part of the identified problem with coverage for ambulatory service. While it addresses the obvious need for adequate facilities, it ignores the desirability of having the patient treated by his personal physician. When treatment is provided by another physician, unnecessary repetition of tests and longer hospital stays often result, increasing the cost of medical care. It is recognized that there are instances which preclude taking a patient to the hospital where his physician has privileges (i.e. when there is an unreasonable distance to travel or when there is an emergency requiring prompt treatment). However, it is often expensive to deny a patient treatment by his personal physician in the absence of such conditions.

SECTION 44—DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

This section would prohibit the release of names of physicians who have been paid large amounts for treating Medicare or Medicaid patients except as required by other laws, i.e. the Freedom of Information Act. We interpret this to mean that the Secretary cannot routinely provide such lists, but still must comply with the request under the Freedom of Information Act.

Although we applaud this provision as a step in the right direction, we urge you to extend it to completely prohibit the release of physicians' Medicare program payments. Past experience indicates that little is accomplished by such lists other than unfairly implying wrongdoings by many honest physicians.

STATEMENT OF THE AMERICAN SOCIETY OF ORAL SURGEONS

The American Society of Oral Surgeons ("ASOS") is the official organization of nearly 3,700 oral surgeons representing all fifty States, the District of Columbia and Puerto Rico. Today all members must complete 3 or more years in an accredited surgical residency in a hospital following completion of 4 years of dental school. Members limit their practice to oral surgery in offices and in hospitals as staff members.

ASOS is submitting this statement first to bring to the attention of the subcommittee two important inequities in the reimbursement provisions under present medicare laws. S. 1197 has been introduced by Senator Dole and would correct these two inequities. Correction of the first inequity described below would not expand covered services and thus would not increase the cost of the present medicare program. Accordingly, reform of this matter by amendment to S. 1470 would be consistent with the aim of this bill, and ASOS urges such an amendment. The second inequity herein discussed involves a modest increase in costs and in the judgment of the subcommittee may be more appropriately dealt with as part of other legislation.

I. ELIMINATE DISCRIMINATION BETWEEN PHYSICIANS AND ORAL SURGEONS AND OTHER DENTISTS IN THE PROVISION OF COVERED SERVICES

Many of the professional services presently provided by both oral surgeons and other dentists and physicians are only reimbursed when they are provided by physicians. The ASOS asks the subcommittee to include in the bill presently being considered provisions that will eliminate this discrimination. The requested correction will not increase the costs of medicare.

The professional practice of oral surgeons overlaps with that of physicians to a significant extent. Both groups, for example, often admit their patients to hospitals and perform complicated maxillofacial procedures. Further, both groups often provide diagnostic care and treatment of oral infections. Medicare, however, will pay all benefits for these services if they are performed by a physician, but the Medicare Intermediary will routinely reject the payment request if the diagnostic care or treatment of oral infection was performed by an oral surgeon.

Under present law, medicare only covers the services of dentists when they constitute so-called "physicians' services." It is necessary, therefore, to look at the definition of "physician" in deciding whether a specific service is covered. "Physician" is defined to include a doctor of dental or oral surgery licensed by his State "but only with respect to" (1) surgery related to the jaw or any contiguous structure or (2) reduction (that is, the alignment) of fractures of the jaw or any facial bone.

As existing medicare law is interpreted by the Social Security Administration, a dentist only functions as a "physician," and his services are only covered, when he is involved in the actual performance of surgery or reduction. Thus the law seriously discriminates against oral surgeons by excluding important nonsurgical functions (such as the management of salivary gland infections) which are covered only if performed by a physician. None of these functions involves routine dental care, which is separately excluded under existing law whether performed by an oral surgeon or physician. No logical reason exists to support this unfair treatment. Both disciplines are professionally trained and licensed by state law to perform these procedures.

This problem has serious consequences for the patient, and is important to the professional life of the dentist. If the patient is aware of the discrimination, his freedom of choice of provider between a physician and a dentist will be prejudiced. If he is not aware of this legal pitfall when he is treated by an oral surgeon, he will be deprived of reimbursement for what surely must appear to him a completely arbitrary distinction.

To put this problem into concrete terms of actual cases as illustrations, the Social Security Administration's interpretation of present medicare law:

- denied payment to a patient for the services of an oral surgeon who had been called to the emergency room by the patient's physician to locate a bullet in the patient's tongue;

- forced a 73-year-old woman to find her own means of paying for an oral surgeon's evaluation of oral and maxillofacial injuries suffered in an automobile accident;

- denied reimbursement to an elderly man who was treated by an oral surgeon for temporomandibular (jaw) joint arthritis;

- denied payment for drug injections administered by an oral surgeon to a facial nerve of a patient suffering from tic douloureux, the most painful and debilitating of all facial pains; and

- denied payment to a patient for treatment by his oral surgeon of an obstruction and swelling of a salivary gland.¹

These are not isolated examples. The files of our Society contain numerous similar cases. The problem is serious and it needs prompt correction.

The solution provided in S. 1197 will not increase the scope of covered services. The existing exclusion of coverage of routine dental care found in § 1862(a) (12) would not be changed. Those services that fall into this category would still not be covered. The solution of this problem will merely assure that patients will not be denied reimbursement for otherwise covered services solely because of the academic degree of the provider.

II. COVER INPATIENT HOSPITAL SERVICE FOR ALL DENTAL PROCEDURES THAT REQUIRE HOSPITALIZATION

The second area of concern in medicare which the ASOS would like to bring to the attention of the subcommittee concerns reimbursement for hospitalization required by the severity of a patient's dental condition. To correct this problem will increase benefits and thereby the cost of the program by a relatively modest amount. The subcommittee, therefore, may want to deal with this matter in other legislation.

Existing medicare law differentiates between cases in which the dental procedure itself is a covered service (and thus the dentist's fee is reimbursable) and cases involving noncovered procedures. If the procedure is covered, the inpatient hospital expenses are also covered. However, the present Medicare statute as interpreted by the Social Security Administration restricts the payment of inpatient hospital expenses in the case of a noncovered dental procedure

¹ The ASOS has compiled a binder of documented examples of cases where this serious inequity has created problems for patients. This binder is available for the review of the Subcommittee and its staff.

to circumstances in which the patient's underlying medical condition, and not solely his dental condition, requires hospitalization. The only example of a medical condition justifying the hospitalization of a patient for a noncovered dental service given in the Social Security Administration's "Intermediary Manual" is "a patient who has a history of repeated heart attacks who must have all of his teeth extracted."

The effect of existing law is to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of his dental condition alone requires hospitalization for the safe performance of a noncovered dental procedure. In these cases the patient must find his own means of payment for the hospital expenses. Sample medicare rejections when contrasted with the example in the S.S.A. manual starkly demonstrate the problem under present law. For example:

—an 81-year-old woman in Florida who was hospitalized by her oral surgeon for the removal of six maxillary teeth had her claim rejected because the medicare intermediary found that she was treated for a purely dental condition;

—a 93-year-old man in Illinois who was hospitalized by his oral surgeon for the extraction of eleven seriously diseased teeth had his claim denied; and

—in Missouri a medicare patient had to pay his own hospital bill because he was hospitalized by his oral surgeon for preparation of the lower jaw for dentures using a skin graft.

These are only three of the examples regularly received by our Society every year but they graphically illustrate the problem.²

ASOS urges and S. 1197 provides that medicare should cover inpatient hospital expenses if in the judgment of his dentist the severity of a patient's dental condition requires him to be hospitalized for performance of a dental procedure notwithstanding that the procedure itself is not a covered health service. This will not increase the coverage of dental fees. It will only increase hospital coverage and aid the patient. The Social Security Administration in 1973 estimated the additional first-year Federal costs of coverage of medicare patients in such instances to be \$4 million.

STATEMENT OF THE AMERICAN SPEECH AND HEARING ASSOCIATION

On behalf of the 27,000 speech pathologists and audiologists who comprise its membership, the American Speech and Hearing Association is pleased to offer its support for S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act. The need to streamline the administration of the medicare and medicaid programs in an effort to stem the tide of a federally supported health care costs under these seemingly insatiable budget monsters is apparent. We further applaud your effort to meet the fiscal crisis created by rapidly escalating health care costs by focusing on cost effectiveness rather than curtailment of essential health services.

Our statement will address three concerns directly related to the fiscal constraint objective of the legislation: (1) the need for a technical modification of title XVIII, endorsed by the Senate Finance Committee in 1973 but never passed into law, clarifying the physician-speech pathologist relationship; (2) the dilemma created by the application of Medicare standards to all patients served by outpatient facilities; and (3) the ballooning of medicare outlays spawned by the need to provide speech and hearing services "under arrangements."

Physician-speech pathologist relationship

Since the initiation of the medicare program, speech pathologists have experienced frustration in their efforts to serve the needs of the communicatively-impaired elderly. The law requires that speech pathology services be provided according to a patient plan of care formulated by a physician, and reviewed by that physician at 30-day intervals. This restriction on speech pathology services represents a precedent-shattering disregard for the traditional physician-speech

² As in the case of the first inequity discussed in this statement the ASOS has compiled documented examples of this problem. These are also available for the use of the subcommittee and its staff.

pathologist relationship long accepted by both professions, and inevitably impacts adversely upon communicatively-impaired Americans. The speech pathologist is the only health care provider qualified by training and experience to evaluate a speech impairment and formulate a plan of therapy specifically designed to remediate that impairment. In the absence of a medical specialty in speech, the physician-prescription requirement merely necessitates a cumbersome and expensive rubber-stamp procedure that results in the wasteful, nonproductive expenditure of Federal health care dollars.

The prevailing requirement for a physician's prescription and review of medicare speech pathology services is the product of a legislative mishap. In 1972, Congress most appropriately extended medicare coverage of speech pathology to those services rendered in such outpatient facilities as clinics, rehabilitation centers, and public health agencies. But, in end-of-session haste to pass the legislation which became Public Law 92-603, bill drafters analogized the provision of speech pathology to physical therapy services in Section 1861(p) of the Social Security Act. The unfortunate—and unintended—result is that the law now contains an inappropriate provision requiring that a physician prescribe a plan of treatment and recertify the need for speech pathology services every 30 days. Not only does this requirement for Federal reimbursement abrogate the traditional physician-speech pathologist relationship long accepted by both professions, but it costs the communicatively handicapped, medicare, and, ultimately, the American taxpayer countless thousands of dollars in unnecessary physicians' fees.

In 1973 the Senate Finance Committee sought to correct this legislative oversight in its report on H.R. 3153:

The provision in Public Law 92-603 unintentionally penalized the speech pathologist. By incorporating through reference certain requirements applicable to physical therapy, the provision seemed to require that there must be not only a physician's referral but also a specific physician's plan detailing the amount, duration and scope of services to be provided by the speech pathologist. Since speech pathology involves highly specialized knowledge and training, physicians generally do not go into this type of detail when referring a patient for these services. [See attachment, S. Rept. 93-553, pages 66-67.]

Unfortunately, the committee's effort to clarify congressional intent came to naught when, with only hours remaining in the 1973 session, House-Senate conferees agreed to put H.R. 3153 aside and report a skeleton compromise bill (H.R. 11333) providing an increase in social security benefits.

We sincerely hope that in its report on this legislation the Finance Committee will seize the opportunity to reassert the recommendation made in 1973, using S. 1470 as the bridge from affirmation to implementation.

Outpatient rehabilitation agency dilemma

Another critical problem stemming from overutilization of the physician as the sole entry to health care services surfaced this year when outpatient speech and hearing clinics began applying for medicare certification as rehabilitation agencies. Clinic directors were informed by medicare surveyors that, under the June 1976 regulations promulgated by the Bureau of Health Insurance to implement Public Law 92-603, speech and hearing clinics must maintain records which include a physician's prescription and 30-day review of treatment plan for "All" individuals served by the clinic.

Speech and hearing clinics now find themselves caught between a rock and a hard place: (1) a clinic can revamp its operating procedures to accommodate the medicare requirement, or (2) it can decline to accept Medicare patients. Since medicare beneficiaries would represent only a fraction of a clinic's total caseload, and since the expenses that would be incurred in opting for the first choice would be prohibitive—both to the clinic and to its private patients—in point of fact there is no legitimate, feasible option available. Thus the overly restrictive requirement shuts the door on what may well be the only source of services in the face of the elderly speech impaired—the very individuals whom Congress sought to serve by extending the medicare program to cover outpatient speech pathology services!

BHI staffers have been sympathetic and diligent in seeking a solution to the dilemma that would not violate medicare's equal treatment standard. A directive has been issued to regional medicare officials exempting from the physician-

prescription requirement all referrals from "normal sources," defined by BHI as "education institutions, State and local rehabilitation agencies, crippled children's programs, or other education or social organizations of record." But BHI's action offers only a partial solution, leaving unanswered the plight of the private patient who would be required to incur the additional expense of a monthly visit to his physician.

In effect, congressional intent has been short-circuited by the regulation which attempts to put it into motion. There is a special irony in the fact that a standard intended to assure that medicare beneficiaries receive quality health services, in a par with private patients, actually bars the medicare recipient from receiving the service at all!

Wasteful administrative procedures

The law presently denies the speech pathologist recognition as a qualified medicare provider, making it necessary for speech pathology services to be rendered "under arrangements" with a certified medicare provider—hospital, extended care facility, or home health agency. The medicare provider bills the fiscal intermediary for the speech pathology service and subsequently reimburses the speech pathologist according to the terms of the contractual arrangement between the provider and the speech pathologist.

The paperwork required by such convoluted administrative procedures pads the nation's medicare bill and represents an unjustifiable waste of precious health care dollars. In some instances, institutional middlemen are not only skimming the cream off the top, but taking most of the milk too, charging the medicare program anywhere from 20 to 100 percent for administrative costs. Recognition of the speech pathologist as a qualified medicare provider would put an end to this unnecessary and extravagant drain on the program's resources.

In some instances medicare-certified facilities have declined to accommodate the cumbersome administrative procedures involved in providing speech pathology services for medicare patients. Again, as in the case of outpatient clinics, the tragic result is significantly reduced accessibility to speech pathology services for many communicatively-handicapped elderly.

Summary

Long overdue recognition of the speech pathologist as the health professional best qualified to provide services for communicatively-handicapped individuals would substantially alleviate the three problems outlined above. While this Association readily accepts the physician's status in providing medical services, the physician does not offer and cannot provide necessary therapy for the remediation of speech impairments. The restrictive physician-prescription requirement, in its failure to acknowledge the widely accepted professional independence of the speech pathologist, ignores the many years of highly specialized academic and clinical training required to attain the high standards of the speech pathology profession and imposes on physicians a responsibility for which they are not trained and which, quite naturally, they do not want. The clumsy rubber-stamp procedure that results is wasteful and costly both for the communicatively impaired and the medicare program.

STATEMENT OF THE ASSOCIATION OF PATHOLOGY CHAIRMEN, INC.

The Association of Pathology Chairmen (APC) strongly supports the efforts of the College of American Pathologists to establish a relative value scale for the professional responsibilities of pathologists as such relate to patient care. Teachers of pathology in academic medical centers often devote significant amounts of time and effort to such responsibilities and a significant fraction of these persons' salaries are thus derived from patient care income.

With respect to the autopsy, a relative value scale also is desirable. The professional input involved in autopsy pathology varies greatly depending upon individual circumstances. Reimbursement should reflect such variability. Some categories of autopsies that have been provided include:

1. Stillborn infants.
2. Autopsy limited to select organs or regions of the body by request of the family.
3. Complete autopsy with detailed examination of the central nervous system.

4. Autopsy of individual with suspected familial or communicable disease where intense counseling of appropriate family members by the pathologist may be indicated.

5. Autopsy with forensic or environmental implications—examples include not only cases of suspected homicide, etc., but also situations where possible environmental influences (radiation, various dusts, asbestos, etc.) may have caused disease and may be the basis of future litigation.

It is important to emphasize that academic departments of pathology are often responsible for the more complicated autopsies since difficult clinical problems are often referred to these institutions for diagnosis and treatment. In addition, provision should be made in the law for new responsibilities and activities as such develop. For example, extensive grief counseling of parents of children with the sudden infant death syndrome (SIDS) now appears to be of significant value to the involved families and will probably be undertaken by all pathologists on a universal basis in the not too distant future.

Thank you for your attention to the above.

ELLIS S. BENSON, M.D.,
President Association of Pathology Chairmen.

STATEMENT OF THE BLUE SHIELD ASSOCIATION

This statement on S. 1470 is presented on behalf of the Blue Shield Association, which represents 70 locally-based, not-for-profit, medical care prepayment plans. These plans cover 72 million private subscribers, and serve 12 million beneficiaries under the medicare program. In fiscal year 1976, including the transitional quarter from July through September of 1976, 32 Blue Shield part B carrier plans processed almost 72 million part B claims, or approximately 62 percent of the total medicare part B claims.

This subcommittee is to be commended for addressing the problem areas of medicare and medicaid and exploring the need for reform in these programs. The Blue Shield Association appeared before this subcommittee last year and expressed its views on this subject. We are pleased that many issues of concern to us at that time have either been resolved or eliminated from S. 1470.

We support your commitment to the development of reforms to deal with the increasing cost of these programs and to promote incentives to encourage increased efficiency. Your previous actions and consideration of this bill demonstrate an awareness of the enormity of the problems faced by both the government and private sector. Although there have been improvements in these programs, we recognize that some problems are still unresolved.

A major problem with medicare continues to center around reimbursement for services of physicians and other providers. This has been one of the chief causes of dissatisfaction among both beneficiaries and physicians. The inflationary trend in the economy has moved rapidly, and the Medicare reimbursement formula no longer achieves the original objective of a paid-in-full program. We pointed this out last year before this subcommittee. We again emphasize our concerns in this area. Under the present formula the beneficiaries' portion of health care costs has been steadily increasing. The reason for this is not clearly understood by the public and the consequences reflect adversely on both the program and carriers.

We recognize the difficulty of balancing a desire to keep costs down with the establishment of a range of fees which will be accepted as reasonable by physicians and other providers. However, until this problem is resolved, dissatisfaction among physicians and beneficiaries will continue to exist.

We have urged Congress on many previous occasions to choose between a true paid-in-full program or a limited liability program. Once a decision is clearly made both the public and providers can be properly informed of what the program does and does not provide. However, if the intent is to provide an 80 percent of reasonable charge program with provider cooperation and program acceptance, it is our opinion based on many years of experience that there must be predictability based on current reasonable charges to induce such provider cooperation.

Another area of concern to us is the need to improve program administration. This can best be accomplished by concentrating more at the operational or carrier level where the most effective and long-last reforms must begin. A posi-

tive step would be to allow carriers to utilize fully their expertise and capabilities for which they were originally selected. We urge more consideration in these areas.

One proven approach is to hold carriers accountable for end results and give them more discretion on the processes used to achieve those results. Excessive legislative and regulatory specification of the processes to be used is counterproductive and costly to everyone.

We support reasonable standards to be met by carriers. However, these should be fixed by regulation rather than by law. It should be the carrier's responsibility to achieve these standards, using effective methods of its own choice. Our experience shows that this is the best way to get results and we recommend that Congress follow this approach.

We would now like to offer comments on a few specific sections of S. 1470. Our statements are intended to be constructive and supportive of the desired improvements in medicare and medicaid.

Use of approved relative value schedule, section 15

In general, we support the intent of this provision. It is a commendable idea, especially if it is used to assure that a tool is available for carriers and providers in achieving proficient administration, cost effectiveness, and adequate pricing.

The bill allows the Secretary to adopt a specific terminology system and its relative values for use by carriers in calculating reasonable charges for medicare. However, the language is silent on how the conversion factors, if any, would be determined. We urge that the report of this subcommittee make clear that these provisions are not to be interpreted to mean that the Secretary of HEW would establish a national fee schedule by setting the conversion factor. Such a "national fee schedule" that failed to take into account local and regional differences would be neither fair nor equitable. We also recommend that this section not be construed to prohibit the use by the Secretary of any existing terminology system. Existing systems should be considered before any attempts are made to develop a new system for use under this provision, to minimize proliferation of terminology systems.

We also have some concerns regarding subsection (e). This subsection appears to permit comparable use of the nomenclature and relative value systems developed under this proposal for activity not related to title XVIII. We would request that the subcommittee report state clearly that private business use by carriers of the title XVIII nomenclature and RVS would not be a violation of any existing laws or be subject to Federal Trade Commission or Justice Department action.

Finally, we recommend that the provisions of this section not be construed to allow or require the establishment of a single medical terminology system. While we support the establishment of uniform terminology for medicare and medicaid, cost considerations mandate that carriers be allowed the flexibility to use their own coding systems in their private business.

Agreement to accept assignment—section 10

This section would allow a physician an option to become a medicare "participating physician." As a "participating physician," the physician would accept an assignment of claim for each service performed for an individual involved in part B. In addition, participating physicians would be able to submit claims on a simplified basis, including multiple listing of patients. Physicians would receive an additional \$1 for each such claim submitted.

We support the intent of this section in providing incentives to encourage physicians to accept universally assignments under the Medicare program. For any full payment program to work with consistent predictability, there must be a commitment in advantage by the physician. However, if this concept is to be successfully implemented, physicians must have confidence that reimbursement for their services will be fair and equitable and based on current reasonable charges.

While we support the provisions of this section that would reduce paperwork by having simplified claim forms and reimbursement for preparing these claims, we have doubts that these incentives alone are sufficient to encourage a significant improvement in participation by physicians. Blue Shield has traditionally utilized the participating physician concept. We would hope to have the opportunity to consult with the members of this subcommittee and its staff in this regard.

Regulations of the Secretary—section 32

If promulgation of any regulation is deemed urgent, this section modifies the time for such proposed regulation to become effective after it is published and sets a maximum time for regulations to become effective for this act. The language of the bill requires the Secretary to indicate whether prompt promulgation is urgent when a proposed rule or regulation is published in the Federal Register. Where such urgency is indicated, the rule or regulation would become effective within sixty days after the notice is published.

We appreciate the fact that a need may occasionally arise for rapid implementation of rules and regulations. Reasonable and timely implementation of such rules and regulations is a desirable goal. However, we would hope that the intent of this section is not to bypass the opportunity for effective comments and recommendations from interested individuals and organizations.

In addition, we are of the opinion that a reasonable time should be allowed to receive comments on the Secretary's determination of the urgency of the situation.

Finally, as we have before, we recommend that interested parties be given additional opportunities to present their recommendations and comments. This could best be accomplished during the drafting stages of a proposed regulation.

Repeal of section 1867—section 33

This section would repeal section 1867 of the Social Security Act. In effect, this would terminate the Health Insurance Benefits Advisory Council. We objected to this proposal last year and continue to do so. There is a need for an effective voice in this area. This function will become even more important if the reforms suggested in this bill are implemented. We recommend that this section be eliminated from S. 1470 and rewritten to strengthen HIBAC to make it an even more effective body. HIBAC plays a vital role as a consultative body on a wide variety of policy and regulatory questions.

CONCLUSIONS

To summarize, we recognize that some reform is still needed. In general, we support this proposal to the degree that it can be effective in accomplishing this goal. However, we believe flexibility and realistic incentives are key factors in achieving lasting improvements, and that additional legislative attention is needed to assure them.

Thank you for the opportunity to submit our views on S. 1470.

STATEMENT OF THE CALIFORNIA MEDICAL ASSOCIATION

The California Medical Association appreciates this opportunity to submit its comments regarding the proposed legislation, S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

We applaud the efforts of this committee to respond to the many problems that are faced in the medicare and medicaid programs. We are aware, as you are aware, that the most pressing of these problems is the continued escalation of costs of medical care. Our comments will be limited to the specific sections of the bill which deal with the physician community. The main thrust of our testimony concerns the practitioner reimbursement reforms, as well as several of the miscellaneous sections of the legislation.

Under the bill, there would be multiple classifications for physicians who care for medicare-medicare patients. Present practice is to allow the physician to accept or reject assignment on each individual patient. This legislation proposes a new alternative called a "participating" physician. A participating physician is an MD or DO who voluntarily and by formal agreement accepts the medicare reasonable charge determination on assigned claims basis as a full billing amount for all services to all medicare patients. Once the physician has signed this agreement he would be allowed to submit his claims on a simplified basis. We understand that this would be a line-by-line submission of claims which would be given priority handling by the part B agent. In addition, the physician would receive a dollar per eligible patient as an administrative cost saving allowance that would be included with his reimbursement for the line item billed claims.

This use of inducements to encourage the acceptance of the Medicare assignment is recognition of the lagging assignment rate. This provision of the bill, utilizing the dollar bonus to the physician, does not reach the issue of why the assignment is so little accepted.

In addition, if there is a method available, such as the multiple-line billing, which can save administrative expense to medicare and the physician, why is it not universally employed for all assigned claims? Physicians are entitled to early and timely payments without the necessity of a statutory mandate. Payment should be prompt, whether or not the physician signs a formal agreement with HEW.

It should also be observed that in seeking to foster acceptance of assignments, the bill itself is ambivalent. In one section it seeks to provide inducements for assignments, while in another, as discussed below, it discourages assignments through imposition of further discriminatory payment mechanisms.

Under section 11, a new prevailing statewide charge level would be established. The bill specifically provides that the prevailing charge level shall cover 100 percent of the charges made for similar services in the state. Based on this determination, a new limitation is then imposed through the operation of the economic index. To the extent that any prevailing charge in a locality is more than one-third higher than the statewide average, it could not be increased on an annual review.

This provision would not reduce the prevailing charge currently in effect, but would put the lid on increases in charges in urban areas, tending to equalize fees in varying parts of the state. This would be discriminatory and unequitable to the extent that wages and services vary markedly by location, and by rural and urban characteristics. Medicare has always based its payments on the differences in localities. It is essential that the law continue to recognize these significant differences in costs between urban and rural settings.

Section 12 of S. 1470 would establish a restrictive definition of physician services for physicians associated with hospitals. We strongly object to such a limited definition of service. A strict application of the language in this legislation would adversely and unfairly affect payment to pathologists and anesthesiologists. The California Medical Association feels that physicians should be permitted to arrange equitable reimbursement agreements with other consenting parties.

It does not seem appropriate for Congress to direct the practice of medicine by defining which physician services qualify as medical care. PSRO's are given the charge to determine the propriety of medical services. The Congress should allow PSRO to begin to function before adding additional standards which could be in conflict with the existing review mechanism.

It cannot be assumed that contractual agreements necessarily result in excessive fees or in fact are unequitable, nor can it be assumed that equating the physician's customary charge with a reasonable salary plus additional hospital and physician costs will be an equitable approach. This legislation should not provide an inflexible limit as to permissible contractual situations between physicians and other parties, as these situations vary.

We would like to turn now to section 15 of the bill that deals with the use of an approved relative value study. The legislation calls for the development of basic terminology which would be published in the Federal Register. Interested groups would have six months in which to propose values for the terms that have been developed. We feel that this section of the legislation could be beneficial to the standardization of terminology in relative values regarding the basic procedures of medicine. As the committee is aware, there has been much discussion with the Federal Trade Commission regarding the use of relative value studies. This provision would provide an opportunity for the studies to be fairly tested.

RVS studies do not have an independent effect on the aggregate cost of medical care, but they do assure that compensation is appropriate to the service in relation to other services. Standardization of procedures provides a common language for the profession. We would urge that existing relative value studies, which have been in use in this country for over 20 years, be recognized in evaluation of medical care.

We would also like to indicate our support for section 44 of S. 1470. This language would prohibit the release of the names of physicians who have been paid large amounts for treating Medicare patients. While this information should be available and is useful to administrative agencies, the publication of this information is unnecessary and has, in the past, been inaccurate. In addition, it has been an embarrassment to physicians who treat a large number of the elderly.

In summary, our support or opposition to specific sections of this legislation is outlined below:

The California Medical Association supports the use of the relative value concept . . . supports the nondisclosure of aggregate payments to physicians . . . has severe reservations about the proposed system for reimbursement of providers . . . opposes the limits on the definition of physician services to specific categories of physicians, namely pathologists, anesthesiologists and radiologists.

There should be no discrimination with regard to participation in medicare-medicaid acceptance of assignments. Those physicians accepting assignments should be able to bill on a line item basis and receive the cost saving benefit proposed.

The section on definition of physician services needs to be broadened to allow for professional judgment and discretion in developing what truly is a physician service for a hospital based physician.

We believe that medicare payments can and should be revised. The payment mechanism should reflect the same sensitivity which Congress showed when it enacted the medicare law. Congress, in enacting medicare, stated its desire to provide quality medical care for the elder segment of our population. This high quality service provided for patients must be paid for at a proper level, and the physicians involved in caring for the elderly should be reimbursed on a usual and customary and reasonable basis.

The California Medical Association urges you to consider our recommendations and comments, and in closing we would like to offer our expertise in any way possible to assist you in developing or modifying this legislation for the benefit of all.

COMMENTS OF THE CALIFORNIA MEDICAL ASSOCIATION

The California Medical Association appreciates this opportunity to submit its comments regarding the proposed legislation, S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

We applaud the efforts of this committee to respond to the many problems that are faced in the medicare and medicaid programs. We are aware, as you are aware, that the most pressing of these problems is the continued escalation of costs of medical care. Our comments will be limited to the specific sections of the bill which deal with the physician community. The main thrust of our testimony concerns the practitioner reimbursement reforms, as well as several of the miscellaneous sections of the legislation.

Under the bill, there would be multiple classifications for physicians who care for medicare-medicaid patients. Present practice is to allow the physician to accept or reject assignment on each individual patient. This legislation proposes a new alternative called a "participating" physician. A participating physician is an MD or DO who voluntarily and by formal agreement accepts the medicare reasonable charge determination on assigned claims basis as a full billing amount for all services to all Medicare patients. Once the physician has signed this agreement he would be allowed to submit his claims on a simplified basis. We understand that this would be a line-by-line submission of claims which would be given priority handling by the part B agent. In addition, the physician would receive a dollar per eligible patient as an administrative cost saving allowance that would be included with his reimbursement for the line item billed claims.

This use of inducements to encourage the acceptance of the Medicare assignment is recognition of the lagging assignment rate. This provision of the bill, utilizing the dollar bonus to the physician, does not reach the issue of why the assignment is so little accepted.

In addition, if there is a method available, such as the multiple-line billing, which can save administrative expense to Medicare and the physician, why is it not universally employed for all assigned claims? Physicians are entitled to early and timely payments without the necessity of a statutory mandate. Payment should be prompt, whether or not the physician signs a formal agreement with HEW.

It should also be observed that in seeking to foster acceptance of assignments, the bill itself is ambivalent. In one section it seeks to provide inducements for assignments, while in another, as discussed below, it discourages assignments through imposition of further discriminatory payment mechanisms.

Under section 11, a new prevailing statewide charge level would be established. The bill specifically provides that the prevailing charge level shall cover 50 percent of the charges made for similar services in the state. Based on this determination, a new limitation is then imposed through the operation of the economic index. To the extent that any prevailing charge in a locality is more than one-third higher than the statewide average, it could not be increased on an annual review.

This provision would not reduce the prevailing charge currently in effect, but would put the lid on increases in charges in urban areas, tending to equalize fees in varying parts of the state. This would be discriminatory and unequitable to the extent that wages and services vary markedly by location, and by rural and urban characteristics. Medicare has always based its payments on the differences in localities. It is essential that the law continue to recognize these significant differences in costs between urban and rural settings.

Section 12 of S. 1470 would establish a restrictive definition of physician services for physicians associated with hospitals. We strongly object to such a limited definition of service. A strict application of the language in this legislation would adversely and unfairly affect payment to pathologists and anesthesiologists. The California Medical Association feels that physicians should be permitted to arrange equitable reimbursement agreements with other consenting parties.

It does not seem appropriate for Congress to direct the practice of medicine by defining which physician services qualify as medical care. PSRO's are given the charge to determine the propriety of medical services. The Congress should allow PSRO to begin to function before adding additional standards which could be in conflict with the existing review mechanism.

It cannot be assumed that contractual agreements necessarily result in excessive fees or in fact are unequitable, nor can it be assumed that equating the physician's customary charge with a reasonable salary plus additional hospital and physician costs will be an equitable approach. This legislation should not provide an inflexible limit as to permissible contractual situations between physicians and other parties, as these situations vary.

We would like to turn now to Section 15 of the bill that deals with the use of an approved relative value study. The legislation calls for the development of a basic terminology which would be published in the Federal Register. Interested groups would have six months in which to propose values for the terms that have been developed. We feel that this section of the legislation could be beneficial to the standardization of terminology in relative values regarding the basic procedures of medicine. As the committee is aware, there has been much discussion with the Federal Trade Commission regarding the use of relative value studies. This provision would provide an opportunity for the studies to be fairly tested.

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The section on definition of physician services needs to be broadened to allow for professional judgment and discretion in developing what truly is a physician service for a hospital based physician.

We believe that Medicare payments can and should be revised. The payment mechanism should reflect the same sensitivity which Congress showed when it enacted the Medicare law. Congress, in enacting Medicare, stated its desire to provide quality medical care for the elder segment of our population. This high quality service provided for patients must be paid for at a proper level, and the physicians involved in caring for the elderly should be reimbursed on a usual and customary and reasonable basis.

The California Medical Association urges you to consider our recommendations and comments, and in closing we would like to offer our expertise in any way possible to assist you in developing or modifying this legislation for the benefit of all.

STATEMENT OF THE CATHOLIC HOSPITAL ASSOCIATION

The Catholic Hospital Association represents nearly 900 health care institutions owned and sponsored by agencies of the Roman Catholic Church. Our members operate and manage over 160,000 acute care general hospital beds, making this the largest single system of voluntary hospitals in this country. The Catholic Church of America has a long and distinguished history in the field of health care delivery. Many of the earliest hospitals in this country were established, staffed and operated by the church. Our hospitals seek to serve the whole person, realizing that spiritual care as well as medical care are necessary for the health of a human person. Today, we continue this mission through the combined efforts of over 300,000 people—both religious and laity, Catholic and non-Catholic. This is a system built on strength in a pluralistic society, based on a strong respect for the total human person, and dedicated to the service of all in need of help; persons in the inner city, the aged, the sick-poor, the isolated.

We reaffirm this dedication and commitment. And we call for a renewed effort by all parties involved in health care delivery—Government and private, charitable and investor-owned, institutional and individual—to strengthen, improve and reinforce the voluntary, pluralistic health care delivery system, which we believe is unique to America and offers the highest quality and greatest scope of benefits available today.

We recognize there are abuses in the present system; there is duplication and a disproportionate distribution of services (i.e. in the inner city and the isolated rural sections of our country); there are weaknesses in gaining access to the system. We recognize also that total health care costs have accelerated and that all of us have a responsibility to constrain these costs wherever possible.

But we do take pride in the accomplishments that we have attained. In terms of quality of life and in the ability to service human needs, we have made great progress. We have more yet to do—especially for the poor and the aged—but we must not fall into the trap of derogating what we have and what we have done. In striving to discover and implement reasonable control mechanisms, questionable artificial savings of a short term nature cannot be permitted to confuse and tantalize our thinking. While changes are required, these changes must not destroy the viability of our pluralistic system and must not adversely affect the quality, availability or accessibility of services.

SENATE BILL 1470

You have before you today, a bill which shows the obvious concern and thought which has gone into the problem and which offers many positive advantages. The Catholic Hospital Association would endorse and support the following underlying assumptions which appear to form the basis for S. 1470.

1. *Prospective Reimbursement.*—CHA concurs that former and existing forms or methods of retrospective cost reimbursement are inadequate to meet the demands of the future. Responsible action dictates that, given finite resources, refined methods of budgeting and allocation must be sought and implemented, methods which will eliminate unnecessary expenditures, waste and duplication but which are adequate to insure the continued financial solvency of the provider and which will enable our health care system to grow, modernize and continue

to serve. We therefore endorse the development of a variety of forms for prospective reimbursement as a primary payment mechanism of medicare and medicaid administration.

2. *Incentive Reimbursement.*—Even under a comprehensive system of prospective reimbursement, there may not be sufficient incentives to curb all unnecessary increases in health care costs and utilization. We applaud the proposal in S. 1470 to encourage greater productivity and cost efficiency by introducing a system of "shared savings". Incentive systems offer the best prospects for future cost containment.

3. *Cost Pass-Throughs.*—Unlike other health care cost control proposals now before Congress, there is a greater recognition in S. 1470 that so many of the costs incurred by hospitals and other providers are completely outside the scope of control of the institutional managers. The Catholic Hospital Association is encouraged by the justice of S. 1470 which would permit these "uncontrollable" cost increases to pass-through the reimbursement limits.

4. *State and Private Administration.*—Implicit within the proposal before you today is the promise that the role of the Federal Government in health care regulations will be limited to establishing and monitoring uniform national standards and objectives. The Catholic Hospital Association strongly supports the continued administration of Medicare and Medicaid on a private intermediary and/or state-coordinated basis.

We feel this mechanism may be the most effective way of responding to local needs and insuring the continued existence of the voluntary component within the health care sector.

5. *Applicability and Coverage.*—The Catholic Hospital Association must also commend the Committee for its recognition that the control of health care costs cannot be categorically limited to a single component of a highly diversified industry. Physicians must also be included if the system is ultimately to be effective in restraining unnecessary cost increases. Suppliers and other providers must also be constrained. We question whether S. 1470's application has gone far enough and whether it should include promotion of consumer education and perhaps even limitations on the level of benefits funded and/or promised to the consumer.

6. *The Catholic Hospital Association Recommendations.*—While S. 1470 addresses many of the problem areas facing the Nation and the health care industry. The Catholic Hospital Association would like to make the following suggestions for changes, amendments, and extensions:

A. *Non-Governmental programs.*—One of the obvious limitations on the effectiveness of S. 1470 to restrain health care costs increases, is its applicability only to Medicare and Medicaid. CHA endorses the extension of the principles of S. 1470 to all third-party payors of health care. We do this for two basic reasons: First in limiting only governmental programs, the immediate result will be the creation of a "second class" of medical service for Medicare and Medicaid recipients. These recipients are frequently the ones most in need of the types and kinds of quality health services which now may be denied to them. The aged, the sick-poor, children—these are the statistically high utilizers of services. And these are the ones to whom Catholic health care facilities have most dedicated themselves. Second, the controls falling only on one segment of the diverse reimbursement system can have only minimal impact on the total cost problem and will simply allow the burden of unrestrained costs to be shunted from category to category.

B. *Effective date of enforcement.*—Another drawback to the effectiveness of S. 1470 is its rather protracted schedule of implementation. The Catholic Hospital Association can see no reason why the provisions of the bill could not be implemented on a more accelerated schedule. Most of the cost data and financial reporting mechanisms are already in existence. We believe that an effective program could be operative within 12-18 months, and perhaps earlier with the cooperation of provider/consumer groups.

C. *Quality of care.*—The Catholic Hospital Association believes that issues of quality of care and delivery cannot be separated from those of cost and financial reimbursement. The Nation's health is a priority issue today and in the future. All too often we hear people speaking of cost controls and financing restraints as if they were separate and distinct issues from quality. Thus, S. 1470 must be viewed in light of concurrent efforts to improve the quality, type and scope of services available to the public at large.

Today, we are faced with the situation of one agency of government demanding new and improved services, materials, life-safety equipment, energy-saving and pollution-control devices and on and on, while other agencies of government are demanding dramatic curtailments in capital investment. We are continually new tests and diagnostic procedures being announced to the public, apparently unrelated to the increased costs which are thereafter incurred. CHA encourages the development of national health policies and guidelines and more effective federal coordination of programs.

D. National Health Insurance.—The Catholic Hospital Association urges the early adoption of a universal and comprehensive system on National Health Insurance. Until quality health care services are made available to all the citizens of this country, effectively and at a reasonable cost, the inequities of the current delivery system will only be perpetuated and compounded. We insist, however, that National Health Insurance does not require the nationalization of the health industry. We call for the strengthening and reinforcement of the voluntary pluralistic system which currently exists. This is building on the strength of our past experiences, preserving its viability and diversity. We ask that these guarantees be built directly into the legislation before you today.

CONCLUSION

The Catholic Hospital Association is grateful for this opportunity to present its views, and the views of its membership, in this very important issue. We hope to be able to work with the committee and its staff on finalizing these proposals and implementing the program. Our goal is to fulfill the ministry of social justice and to heal as Christ healed.

CAYLOR-NICKEL HOSPITAL, INC.,
Bluffton, Ind., June 16, 1977.

MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building,
Washington, D.C.

DEAR MR. STERN: Let me start off by stating that I am in complete agreement with the objectives of SB 1470—to stem the impact of inflation on the cost of medical care and to promote efficient use of hospital facilities and resources. I sincerely believe that H.R. 6575, President Carter's cost containment program, will not achieve these objectives and, worse yet, in many instances may impair the ability of efficient hospitals to render effective medical treatment. While I do not relish the idea of further Federal regulation of hospitals, I believe that SB 1470 may accomplish a great deal in terms of cost containment without penalizing hospitals that have been efficient and well run in the past. My remarks will be directed at various provisions in SB 1470 which I feel need revision as well as suggestions for possible alternative solutions.

My background in cost containment

I have extensive experience in the administration of hospital operations and in various aspects of accounting for and financing of hospital operations. I am a practicing urologist, the President of the Caylor-Nickel Hospital, and Managing Partner of the Caylor-Nickel Clinic. (Enclosed is an article from the AMA News which describes the operation and history of our operation.) Our hospital is efficiently run and has many cost savings and innovative techniques. We are constantly aware of the need to keep the cost to the patient, the government and the insurer at a minimum while still giving the very finest care that is available.

However, we were not always able to provide quality medical care on a cost efficient basis. We achieved this objective through a long range program which included a complete reorganization of the corporate structure and accounting systems, as well as major construction of new facilities and renovation of existing facilities;

The following is a representative list of administrative projects instituted in connection with the reorganization:

Establishment of a collection and credit department;

Centralization of purchasing functions and use of in-house computer facilities;

- Upgrading of the personnel department ;
- Improvement of the pharmacy distribution and cost system ;
- Replacement of contract laundry service with in-house facilities ;
- Development of a volunteer program ;
- Organization of budgeting, materials management ; and
- Establishment of medical audit and departmental objectives generally.

In addition, we are now in the process of changing computer systems which should save the hospital approximately \$5,000 a month and at the same time provide better service.

In connection with our construction and renovation projects, we were required to rely rather heavily on borrowed funds. In this regard our hospital was involved in the issuance of \$6 million of bonds in 1974—the first series of bonds issued under the Indiana Hospital Authority Act. A second \$6 million bond issue was subsequently required. Late in 1976, both of these bonds issues were refinanced with a total cumulative interest savings to the hospital of about \$700,000.

The net result of our reorganization was the transformation of a hospital with substantial financial problems into an efficient and well-utilized facility. This is borne out by the trend in operating results. For example, in 1972 percentage occupancy had fallen to 64.1 percent. In 1976 percentage occupancy has risen to over 77 percent and was forecasted to be approximately 85 percent in the years 1977 through 1980. In 1972, the average length of stay in the hospital was 9.8 days. This was reduced to 9.3 in 1973, 9.1 in 1974, 8.9 in 1975 and 8.4 in 1976. It is estimated that the length of stay will be further reduced in the years 1977 through 1980.

Significantly, my experience in the financial and cost area is not limited to our hospital and clinic. I am a member of the Board of Directors and of the Executive Committee of the Indiana Health Systems Agency and a Director and Vice President of the Indiana State Health Coordinating Council, both agencies operating under Public Law 93-641, the National Health Planning and Resources Development Act of 1974. I am also on the Finance Committee of the American Group Practice Association and am a member of the Board of Directors of the Old First National Bank.

SPECIFIC COMMENTS WITH RESPECT TO SB 14

Section 2 (b)

The secretary is required to consult "with appropriate national organizations" before establishing a system of accounting for hospitals and for classification of hospitals by size, etc. To avoid misunderstanding, I would suggest that there be a specific comment in the committee reports that makes it clear that the national organizations contemplated include The American Hospital Association and other groups of a similar nature which are able to provide the secretary with in-put from the hospital sector as to hospital problems and suggestions for viable solutions.

The establishment of "an accounting and uniform functional cost reporting system" makes a great deal of sense. However, I suggest that the legislation specifically approve the "Chart of Accounts for Hospitals" of The American Hospital Association as the system required under the Act. Chapter 6 of the Chart of Accounts establishes a system of uniform reporting of revenues and direct expenses of the various services of a hospital regardless of the individual hospital's departmental organization structure. Such an approach allows hospitals to achieve comparability in analysis of revenues and expenses on an annual basis and serves to promote the objectives of this legislation.

I should note that most hospitals in the United States are now using this system. Thus, its adoption as part of this legislation would entail the least overall accounting cost to hospitals generally and would be consistent with the cost containment objectives of the legislation.

In defining "routine operating costs" a number of costs over which the hospitals have no control (e.g. energy costs associated with heating and cooling of the hospital plant, malpractice insurance expenses, etc.) are excluded. While I believe these costs are properly excluded from the limits imposed by the legislation I think they should be included in the reporting system so that hospitals in a given area are able to determine whether those particular costs are out of line with other hospitals in its own area. Such a reporting system would enable the hospital boards to consult with other hospitals who appear to be doing a better job of cost containment.

In subparagraph (E) the personnel component of routine operating costs is required to be adjusted using a wage index based upon general wage levels in the hospitals area. There are some idiosyncracies in the hospital employment situation that may make the application of a general wage index inappropriate. For example, employee salaries in general are lower in hospitals than in industry. In addition in depressed times unemployment in industry may be widespread minimizing the need to increase salaries while hospitals remain fairly well staffed.

In subparagraph (4) there is a provision that allows adjustments at the end of each fiscal year to "take account of unexpected changes in the hospital's classification." Two comments are necessary here. First, such an adjustment should be permitted not only for changes in hospital classification, but also where there are new services approved by the local HSA or sudden changes in the hospital's population. Second, such sudden changes should result in adjustment before the end of the fiscal year so that the hospital facing such a sudden change should not have to face serious problems of cash flow which may in turn influence the quality of patient care.

Cost containment and hospital financing are very complex problems. For example, a hospital doing a good job of utilization control might make their adjusted per diem rate go up while their total revenues went down. There should be a provision in this section to permit an adjustment in such circumstances.

Section 10

The \$1.00 administrative cost allowance paid to each participating physician would hardly be an inducement to physicians when costs for a patient were in the several hundred dollar range. If it is going to be widely used at all, this method would probably need to be changed to 10 percent of some percentage figure so that it fluctuated with the fee that was being charged.

Section 11

The section on criteria for determining reasonable charges for physicians services is always no less than one year behind the actual charges. The physicians must therefore bear the inflation burden from year to year.

Throughout this section the secretary acts as the maker of the regulations, the interpreter of the regulations and the payor. The only alternative is to the courts which is expensive and ultimately results in added cost to the patient. There should be some intermediary body or arbiter of some sort (short of the courts), a kind of ombudsman that would serve both the patient and the physician.

Section 12

The section on Hospital Associated Physicians is specifically directed to the anesthesia and pathology services. In many respects they are unduly restrictive and leave far too much discretion to the secretary. For example, subparagraph (c) of Section 12(2) would indicate that the anesthesiologist must do the induction and emergence and could not then technically allow anyone else to do it. This would seem to indicate that he could not be present and officiate for residents, trainee personnel, or other technically capable personnel. It would seem that the definition of one-on-one assistance of a qualified nature would be adequate and that his availability and attention to the assistants, under these circumstances, should be sufficient.

In the second part of the definition (under subparagraph F) the wording assures that a qualified individual may perform induction and emergence. However, in such case the anesthesiologist's reasonable charge would not exceed one-half of the amount that would have been paid personally had he performed the procedure in its entirety. At no point does it define where compensation could be made to whoever employed the individuals. Under these circumstances, if he did not employ them, someone else should collect. If he is employing them, should that be considered as part of his compensation and taken out of the half that he is reasonably allowed to charge? The definition in this paragraph is rather ill-defined. This section may well be appropriate in anesthesiology if the physician is in a training program and the assistants are paid by other sources. The physician has then invested time and effort into the program and into the training of these physicians and the definition as described would be appropriate. However, if these people are in his employ, such as anesthetists, then he or whoever is paying for them should be reimbursed—but it is neither implied nor stated as to how that is to be done—another place where too much latitude and too much power is given to the secretary.

With respect to pathology services, the changes will cause a considerable amount of the laboratory work to be done outside of hospitals and outside of hospital laboratories, as it would become less compensable to the pathologist. Under those circumstances, it will cost more to the patient and more to the government than leaving current arrangements alone. There is no reason to believe that physicians, getting a percentage of the gross, are taking any more out of the economy than pathologists who charge independently, and these physicians should be recognized as being needed in certain areas. If the need is sufficient, it would seem far more practical to put a ceiling on the percentage and give the secretary some discretionary powers with that percentage.

Making pathologists and other persons under similar percentage arrangements salaried employees might increase costs to the government and to the patient. Hospitals have been under great duress to do things as inexpensively as possible. If there were any way to get services at lower rates and employ the necessary number of people, most hospitals would have done so. It would seem, ultimately, that there would be no cost savings—just a change in the method or quality of the services that were rendered.

Section 15

The use of approved relative value scales appears to be, at least on the surface, an improvement. The relative value scales have proven, to the physicians and to third party payers, to be a reasonable way to relate all charges within a specialty, a group of specialties or to some basic unit. Each specialty has its own relative value scales set up for its own procedures which have been given much consideration as to the equity of the relationship between procedures. Many states have set up relative value scales on a statewide basis. The establishment of the entire relative value scale should not be left totally to the discretion of the secretary. The secretary should be directed, in effect, to accept the relative value scales as they now exist with minor modifications or alterations.

Even if the relative value schedule is not adopted, the secretary of HEW should be made to communicate his medical service terminology and definitions. Terminology is a great problem in the communication between the physician, the fiscal intermediary and HEW. Let me cite an example. The secretary or the fiscal intermediary in Indiana established a routine office visit charge which seems simple enough. But as they defined that routine office visit charge, it is the lowest charge that is made. Without knowing their definition, we, at the Clinic, assumed the California Relative Value terminology and established one charge that is lower than a routine office charge. In fact, the routine office charge is exactly what it says—a routine office visit charge. We have what is called a short visit. After much trying, we got their definition. Our definition was recognized but did not coincide with Medicare. Therefore, patients who had a routine office visit, in our terminology, were paying some \$2 more and Medicare was paying \$2.00 less. In addition to that, Medicare was implying to those patients that they were being overcharged. When we received the full terminology from the medicare office, we found a multiplicity of places where patients have been underpaid. It took some time to solve the problem with the intermediary. All of these things have cost us tens of thousands of dollars in actual time, and have cost the patient hundreds of thousands of dollars. Therefore, I say that this approach in the relative value scale and in the transmission of information between the secretary and the physician is essential and the secretary should be made to communicate.

Section 46

In the section on the rate of return on net equity for-profit hospitals, whether you are a for-profit or not-for-profit hospital, is of little significance. In either event, you cannot function without a surplus. In a for-profit hospital, that surplus is taken out and paid to those people who have put up their funds and abilities to make that hospital functional. In many instances, it runs more efficiently or as efficiently as the non-profit hospitals. However, the non-profit hospitals should have the same margins available to them as these margins may be able to be used for improved care and to offset a year that is not quite so good.

Other sections

As to the other sections of the bill, I have no additional comments except to reiterate that the secretary is given the position of initiating and interpreting the regulations, with no recourse short of taking the secretary to court which is expensive and difficult. At some point, the secretary should be required to be re-

sponsive to those people that he is service: the public, the physicians, the hospital and the Congress. Having been a part of the HSA and the State Health Coordinating Council, and as a physician and hospital administrator, I have seen the frequently arbitrary decisions and bias of the HEW work to the disadvantage of everyone.

A proposed cost saving program

In recent years the capital requirements of hospitals generally required very substantial borrowings. The prime rate has drifted from as low as 6 percent to as high as 11 percent. As a result the interest cost on recent hospital borrowing has been staggering. Hospital authorities issuing bonds, even on a tax-exempt basis, often find that the interest rate is somewhere between 7 to 8 percent.

Part of the reason for such a high rate of interest is the risk that the bonds would not be fully repaid. If these bonds could be guaranteed by an agency of the Federal Government, substantial cost savings could be achieved. The interest rate on new bonds issues and refinancing of existing bond issues could very well be at 4 percent rather than at 7 or 8 percent.

Such a guarantee program could be established through a separate corporation very much like the Federal Deposit Insurance Corporation (FDIC) that guarantees bank deposits. The costs of the corporation could be funded by profits from arbitrage transactions and from fees charged at the time guaranteed tax-exempt bonds are issued. The corporation would therefore not require Federal subsidization and would be self-sustaining just like the FDIC.

Once established, the corporation could also be used as a vehicle for providing financing for short-term equipment and operating loans. At the present time hospitals must borrow money in the retail market for these needs and pay as much as 9 or 10 percent. It would be possible for the corporation to issue bonds at, say 4 percent, to fund depreciable equipment needs for hospitals generally. The corporation would then lease equipment to the hospital with a rental that would be one-quarter to one-half of a percent over the interest cost to the corporation.

If such a program were established, there would be other cost savings. For example, the cost of feasibility studies would be greatly reduced once a project is approved by the local HSA. Rating agency expenses would also be eliminated. The prospectus for the sale of bonds would be reduced substantially in scope and cost.

This corporation would have to work intimately with the local HSAs in the determination of capital expenditures required and also would need complete and sophisticated auditing services. However, these services are already being performed by the government in Medicare audits and might need to be changed only slightly.

I have a more detailed explanation of this plan that I could send you or present personally, if you believe that you, or others, would be interested in it. I believe that a savings of \$25,000/million per year (or more) borrowed for long term money and \$40,000 to \$50,000/million per year for short term credit is conservative.

Sincerely yours,

CHARLES H. CAYLOR, M.D.,
President.

Enclosures.

LITTLE BLUFFTON'S CLINIC IS BIG BUSINESS NOW

PATTERNED AFTER MAYO'S, THIS THRIVING FACILITY BEGAN AS A 10-BED HOSPITAL AND NOW INCLUDES 45 PHYSICIANS REPRESENTING 23 SPECIALTIES AND SUBSPECIALTIES.

By Elliott H. McCleary

Bluffton is a small dot on the map of northeastern Indiana, a farm and factory town of 8,300 separated by some 20 miles of level cornfields from Fort Wayne, the nearest city. On the surface it's like hundreds of other neat, plain, prosperous towns throughout the Midwest. Medically, it's unique, for its Caylor-Nickel Clinic proves again what the Brothers Mayo knew: given the right conditions, top-flight big-time medicine can flourish in a rural setting.

Forty-five physicians, representing 23 specialties and subspecialties, staff the handsome six-story clinic building at the corner of Route 1 and Cherry Street. The building is interconnected with a fully accredited 173-bed hospital that clinic part-

ners built and enlarged with their own money, then gave away to the community in 1972.

A \$5 million hospital expansion program is now underway to keep pace with a current 20 percent annual increase in patient load, now running at 120,000 clinic-patient visits and 52,000 hospitalized-patient days. The clinic and the adjacent hospital draw two-thirds of the patients from the local county, Wells, and the counties contiguous to it, but the rest come from all over Indiana, nearby parts of Ohio and Michigan, and other states.

By word of mouth the fame of Caylor-Nickel has spread far afield. Patients come here for comprehensive executive physicals and for sophisticated diagnosis and treatment. Most medical and surgical problems can be dealt with at the clinic and hospital except for cardiovascular surgery, plastic surgery, neurosurgery, and sophisticated ophthalmological procedures. Recruiting is underway to find physicians to cover the last two categories.

A paradox

Surgery done at the hospital includes the most complicated vascular and chest surgery except for cardiac operations, all kinds of hip and shoulder and other joint replacements, repair of inborn genitourinary defects, and such procedures as implantation of hydraulic genitourinary sphincter and penile prostheses. That's quite an extensive surgical scope for a small-town medical facility.

Ancillary personnel include many pulmonary and physical therapists, a physician's assistant, and an electronics engineer who works closely with physicians in the implantation and monitoring of heart pacemakers.

Paradoxically, the decline of rural medicine in the area has acted only to spur the growth of Bluffton's clinic.

"In the small towns around here," says Richard N. Matzen, MD, chief of internal medicine, "the GP faces what all GPs face: he starts out idealistically and wants to be the best doctor he can be. But he soon is burdened with an impossible patient load and can listen to patients only for the time he feels is absolutely necessary to make a diagnosis or to start treatment. Thus, the patient's needs other than physical aren't well cared for. Finally the patient says to himself, 'Gee, I want to know what's really going on—I'm going up to the clinic.'

"Meanwhile," continues Matzen, "after about five years the overworked young physician says to himself, 'I just can't keep this up. I'm going back to the university to specialize.' He does, and gradually the old doctors remaining die or retire. This has been happening all around us. This is what led to the establishment of our family practice department in 1973."

There are only five physicians in the county or just over the county line who are not members of the clinic, and all are in general practice—one in Bluffton and four just over the border of the county in nearby Markle. The five have not applied for courtesy privileges, although the Bluffton doctor uses Caylor-Nickel X-ray services and sometimes refers patients to the clinic.

The Bluffton medical center originated with a clinic and 10-bed hospital in nearby Pennville, founded by Charles E. Caylor, MD, after he had visited the Mayo Clinic. He relocated in Bluffton in 1917 and, during the 20s, like the original Dr. Mayo, was joined in practice by his two surgeon sons, Dr. Harold D. and Truman E. Caylor.

In 1931, with the addition of Allen C. Nickel, MD (who like "Dr. Harold" first spent years on the Mayo Clinic staff), the group became the Caylor-Nickel Clinic. It was an all-specialist practice that added new specialties as the need arose, until, by the end of the 30s, all major categories were usually represented (then as now it was hard to keep some categories such as ophthalmology filled.)

In 1939 the doctors built a 45-bed hospital connected to the original clinic building, and no longer used the small county hospital in Bluffton, which still continues to serve the area's nonclinic physicians.

The idea was crazy

"When we started out, we were pariahs," recalls Harold Caylor, 82, a general surgeon, who with his brother Truman, 76, a urologist, is still active on the medical staff. "Other doctors thought this group practice idea was crazy. But dad had the idea of the clinic and the motivation—he just worked at it 24 hours a day, seven days a week, and mother helped, too."

"Our father," says Dr. Truman Caylor, "was blind in one eye but he was a damned good surgeon. He was a good person, an ardent Christian. We never turned anyone away. I remember one time trading a patient's bill of \$600 for a bushel of beets."

Growth accelerated after World War II, and payments in produce became rare. By 1969 there were seven partners and 17 salaried physicians in the clinic and a modern proprietary hospital providing general medical-surgical, pediatric, obstetrical/gynecological, and psychiatric services—plus dentistry and chiropody.

But then arose a peculiar and complicated dilemma, explains Charles H. Caylor, MD, 51, son of Dr. Truman Caylor, current president of the hospital board and managing partner of the clinic. "We had more business than we knew what to do with but we didn't have enough money to take care of it. Inflation was coming along and our hospital rates hadn't kept up. Income from the doctors' practices apparently was subsidizing the hospital, and partners and nonpartners alike were unhappy. This stimulated our reorganization."

Genial, pipe-smoking Charles Caylor of necessity had become a man of many hats, a businessman and part-time administrator as well as an outstanding urologic surgeon. Now he had to become a tax expert. For many months he studied tax laws and reorganization procedures, readying himself for the biggest surgical challenge of his career, to sever the clinic from the hospital, without damaging either.

The seven physician partners who owned the hospital could have simply sold it for a large profit to a profit-making hospital chain (an outside appraiser valued the partners' holdings at \$2.5 million). One major chain was prepared to make an offer.

"But profit was not a motive in establishing the hospital initially," says Dr. Charles. "We were working for the very best patient care that we could get at the most reasonable price we could get."

Rates are lower

One of the reasons for the clinic-hospital's popularity had always been that its rates were lower than those of comparable places. This advantage would be impaired if the hospital were sold to an organization that planned to run the hospital at a profit.

"The chain that approached us," says Dr. Caylor, "estimated that they would take away a profit after income taxes of nearly \$3 per patient day, and the income taxes that they'd have to pay would amount to another \$2-\$3 per day. That extra \$5 or \$6 a day would have come out of the patient's pocket."

Another alternative, that of separating the clinic-hospital into a for-profit clinic and a not-for-profit community hospital, seemed preferable. Aside from not having to operate at a profit, the community hospital, as a nonprofit facility, would no longer have to pay local real estate taxes, which came to \$125,000 annually. Moreover, the community facility could finance improvements by means of tax-exempt bonds.

The idea of doing something about taxes seemed particularly inviting. "The tax situation," says Dr. Caylor, "had become such that there was no way of adding any capital improvements without paying state and federal income taxes. We would have been paying off new buildings at the rate of 4 percent a year but depreciating them at only 2 percent a year. That 2 percent difference—2 percent of millions of dollars—would have been subject to taxes."

The decision between these two alternatives was not difficult: In December 1972, the seven owner-partners relinquished ownership of their hospital to a newly created not-for-profit community hospital corporation.

The hospital's equipment had to be handled differently. The partners had previously segregated control of this into a separate corporation, which had then leased the equipment to the clinic and the hospital. They now gave up their personal ownership of the equipment corporation's stock by turning it over to the research arm of the organization—the Caylor-Nickel Foundation. (The hospital later obtained the equipment from the foundation.)

Giving up ownership of the hospital caused some concern about control. "I have known of instances," says Dr. Caylor, "in which doctors gave their hospital to the community and then lost their influence and control."

Partnership expanded

To date this worry has not materialized. It was decided that the hospital would be governed by an 18-man board of directors selected for life. Eleven of the directors must be nonphysicians; those chosen were all local business and professional men. Seven directors are full-time medical staff men at the hospital.

Once the hospital was separated from the clinic, the partnership was expanded to include all 24 physicians on the clinic staff (except one who chose to remain

as an employee). Again profit was ruled out; there was no significant buy-in, although each partner physician contributes \$1,000 annually for four years to the clinic's capital account; the money is returned when he leaves the partnership.

The hospital, now under separate jurisdiction, was able to prove its need for higher rates: In 1972 and 1973, losses totaled half a million dollars, in part because the federal Phase I freeze of health care costs delayed a planned increase in average room rate from \$32 to \$40. Since then the situation has been corrected. Average room rate in February will rise to \$80.

Higher salaries attract physicians

Once the clinic no longer had to subsidize the hospital, it was able to pay higher salaries and attract more physicians. By late 1976 the number of physicians had nearly doubled, from 24 to 45, and so also had the patient load, which has always increased as fast as physicians are added to the staff.

Currently the group is seeking three family practice physicians, two general internists, two cardiologists, a psychiatrist, an ophthalmologist, a neurosurgeon, and at least one gynecologist, and has contracts to employ several other specialists.

New members of the staff, all of whom must be board-certified or eligible for certification, are reviewed yearly by their peers and can be voted in as full partners after the first full calendar year. Those who don't make it in three years generally leave. Most are accepted because each prospective physician is carefully screened.

Physicians on the staff are able to pursue research projects through the clinically oriented Caylor-Nickel Research Foundation, which is financed by a partners' gift of \$750,000 in the past, plus annual \$700 donations from each of the partners and other grants and donations.

STATEMENT OF CENTER ON SOCIAL WELFARE POLICY AND LAW

The following statement on S. 1470 is submitted by the Center on Social Welfare Policy and Law, the only national law office devoted to problems of social welfare law. The Center has over eleven years of experience in representing poor persons affected by public benefit programs, and is currently representing clients with many problems addressed by S. 1470. This statement addresses those points the Center has been able to consider in the time available: delays in determining eligibility, deficiencies in current quality control procedures, inadequacies in current procedures for developing agency policy, consideration of property transferred to relatives without fair compensation, and waiver of human experimentation provision for Medicare and Medicaid. No position is taken on other portions of the bill at this time.

SECTION 31(a): APPLICATION PROCESSING TIME LIMITATIONS

Section 31(a) of S. 1470 would add a section 1902(a)(37) to the Act which would require that a determination of eligibility for medical assistance benefits under title XIX be made within 45 days (60 days in disability cases) from the date of application. Speedy determination of eligibility is clearly a matter of vital importance to all needy persons requiring medical care, since there is no manner in which a person can be compensated subsequently for denial of medical care at a time when it is most needed. Since delays are now commonplace, legislative action such as that reflected in § 4(a) is certainly necessary. There are certain problems arising from the language of § 4(a), or current agency practices, however, which we believe the Committee should address if it wishes to accomplish its benevolent purposes.

Before turning to those problems, we should first note that states should have no difficulty complying with time standards of 45 and 60 days, and that the 30 day and 60 day limits proposed last year in S. 3205 are preferable. A 30 day standard was applied by HEW in the AFDC program from 1951 to 1973; the sixty day standard in disability cases was introduced in 1968. HEW defended its 30 days requirement before the United States Supreme Court in *Rodriguez v. Swank*, 403 U.S. 901 (1971), stating in its amicus brief that the mandatory 30 days standard "was drawn on the experience of more than seventeen years in administering the statute, as well as the experience and comments of various

states and recipients." A number of states who were out of compliance with the 30 day requirement in the early 1970's were brought into compliance by court orders. Even when HEW extended the time period to 45 days in 1973, it recognized that 30 days was the *reasonable* period, and required that benefits be paid as of the 30th day, 45 C.F.R. § 206.10(a) (6) (i).

HEW has not set any standard for promptness of determination of eligibility for SSI in its regulations, and has been under serious criticism for its delays. In an October 21, 1975 Report to the Subcommittee on Public Assistance of the House Committee on Ways and Means, SSA stated that by March 1976 it hoped to determine the average case in approximately 30 days (60 days for disability cases). A March 1976 Report states that those goals were exceeded, that is, that the average case took *less* time.¹ Of course many cases took longer. It is apparent, therefore, that the time standards contained in S. 1470 are certainly attainable, and should be retained in the bill and perhaps tightened up. This brings us to the problems raised by the bill in its present form.

1. We are concerned that S. 1470, as currently drafted, may not have the desired impact in assuring that eligibility determinations will be made within the time limits desired by the sponsors. Thus, S. 1470 could be read to apply the 45 and 60 day time limits for the making of eligibility determinations on "applications for coverage" under the medicaid program only to *medicaid* applications of persons *already receiving AFDC or SSI benefits*. § 31(a) now says:

(37) provide—

(A) for making eligibility determinations on the basis of applications for coverage, within forty-five days of the date of application for individuals: (i) *receiving aid or assistance* (or who except for income and resources would be eligible for aid or assistance) under a plan of the State approved under title IV, Part A . . . , or (iii) with respect to whom supplemental security income benefits *are being paid* (or who would except for income and resources be eligible to have paid with respect to them supplemental security income benefits). . . . (emphasis supplied)

Yet persons "receiving" AFDC benefits, and most persons to whom SSI benefits "are being paid," are automatically eligible for medicaid benefits, and *no* further delay is warranted.² In addition, persons applying for AFDC benefits who are determined ineligible solely on the basis of income or resources should also have had eligibility for medicaid determined in the process of making that determination. In sum, the group of "applicants" for medicaid coverage described by § 31(a) includes those persons who should not be applicants, but recipients, since they are already eligible for benefits.

We therefore assume § 31(a) was designed to reach persons applying for medicaid and cash assistance simultaneously, as well as all other persons seeking medicaid benefits, whenever it is the state agency that is determining eligibility. (Those applicants for medicaid for whom eligibility is determined by SSA pursuant to a contract with the state agency may not be protected by a state plan requirement.)

We therefore recommend that the bill be amended so that the new § 1902(a) (37) (A) read something like the following:

(37) provide—

(A) for making eligibility determinations on the basis of applications for coverage (except on the basis of disability) within 30 days of the date of application whether or not application for benefits is also made under title I, X, and XVI, and Part A of title IV, within 30 days of the date of such application.

Subdivision B could be revised similarly.

A new subdivision should then be added to require immediate determination of eligibility when SSA determinations that a person is eligible for SSI benefits, the state's Title XIX plan provides that the individual is therefore automatically eligible for medicaid, and the state has not contracted with SSA for the determination of medicaid eligibility.

¹ In this respect, it should be noted that S. 1470 allows for cases in which it is alleged that a determination of eligibility simply cannot be made within the 45 or 60 day time limits by providing that the sanction under the Act applies only if timely determinations are made in fewer than 95 percent of all medicaid assistance eligibility determinations. Section 31(c) of S. 1470.

² Thus, under current regulations, persons applying for AFDC benefits and many applicants for SSI benefits do not make a separate application for medical assistance, 45 C.F.R. § 206.10(a) (1) (iv) (A), (B).

2. We believe it most important that the "date of application" be defined, both to assure that poor persons will receive the protection intended by S. 1470 and so that the Secretary and the Comptroller General can measure compliance. HEW measures the date differently in the AFDC and SSI programs. Under recent AFDC regulations and time period for processing applications begins to run only when a "completed application form" has been submitted. 45 C.F.R. § 206.10(a) (6). Since states now require many documents and other verification, substantial time often passes before the application form is "completed." At that point there should be little need for additional time, since the documentation will be so complete. Nonetheless state agencies begin to measure their 45 and 60 day periods from that late date. Prior regulations required the state agency to measure the time period for determining eligibility from the first time the agency was advised of the applicant's interest in receiving benefits [45 C.F.R. § 206.10(a) (1), repealed effective August 15, 1973]. In the SSI program the application is considered effective on the date that any written statement of a desire to receive benefits is filed with the agency, provided that a complete application form is filed thereafter. 20 C.F.R. § 416.335.

We believe the best approach would be to add a section to S. 1470 which combines these prior and current HEW regulations, and modifies them to conform to other portions of § 1902(a) (37), to read along the following lines:

An application may be made by an individual seeking coverage, his designated representative, or someone acting responsibly for him, and may be made in person, by mail, or by telephone, provided that the application form prescribed by the agency is thereafter completed and filed within an amount of time designated by the Secretary.

3. A determination of eligibility does not assure that a person actually receives benefits. Thus, even though the Act currently requires that medicaid benefits "be furnished with reasonable promptness," Section 1902(a) (8), and federal regulations thereunder require that "medical care . . . shall be furnished promptly to eligible individuals without any delay attributable to the agency's administrative process," 45 C.F.R. § 206.10(a) (5), there are often delays between the determination made by the agency and the issuance of documentation (the "medicaid card") establishing eligibility so that a person may receive medical care.

We therefore suggest that the bill include specific language requiring the agency to provide documentation of eligibility immediately upon the determination of eligibility. We also suggest the current federal regulation implementing § 1902(a) (8), set out at 45 C.F.R. § 206.10(a) (3), be added to the Act:

The agency's standards of promptness for acting on applications or re-determining eligibility shall not be used as a waiting period before granting aid, or as a basis for denial of an application or for terminating assistance.

Such provisions will help assure that in each case medicaid benefits will be furnished to needy sick persons as soon as possible. If this can be accomplished, this legislation will have succeeded in improving the lives of untold numbers of needy, sick persons throughout the country.

SECTION 31(A), (C), (D): QUALITY CONTROL

We applaud the Subcommittee's efforts to ensure that state determinations of eligibility in the medicaid program will be as accurate as efficient administration can make possible. While much of the support for a rigorous quality control program with specific federal requirements for the systematic reduction of state error rates will most likely come from those concerned primarily with the enormous cost of the medicaid program and with the impact of waste from the taxpayer's perspective, the individuals and families who depend on the medicaid program for their basic health care have an equal interest in efficient and non-wasteful administration. This is so for two obvious reasons.

First, inefficiency and improper expenditures necessarily reduce the amount of funds available to provide the health services vitally needed. The reduction or elimination of improper expenditures will free local, state and federal funds for expansion, or at least retention, of the amount, scope and duration of health services available to the poor under the medicaid program. The second reason is that inefficient, incompetent and careless administration not only causes improper payments to be made to providers of services, and ineligible persons to receive medical assistance benefits, but such lax administration frequently re-

sults in individuals and families eligible for medicaid assistance being denied such aid despite being entitled to it under state and federal law. It is hard to imagine a greater tragedy than the improper denial of critical medical care to the nation's medically needy.

It appears that the Subcommittee is indeed concerned with state errors that keep eligible individuals off the medicaid rolls as well as those errors which cause ineligible individuals to receive medical assistance. Thus, proposed § 1911 provides that the Secretary shall

(a) determine the eligibility error rates, including cases correctly approved and cases incorrectly denied for each state for the six-month period commencing with the first calendar quarter beginning 6 months following enactment of this title . . .

These error rates will provide the basis for establishing the normative error rates against which an individual state's performance will be measured under the proposed amendment to § 1903(n)(1)(B).³

We have two points to make with respect to proposed § 1911(a). First, while the language of § 1911(a) requires that there be a determination of the states' error rates in a particular future period, it does not specifically provide that those error rates should be based on the states' quality control reports. There should be an explicit reference to the medicaid quality control results as the basis for the normative error rate. We strongly recommend that quality control data provide the basis for determining the error rates, since its results must be based on statistically valid sampling. Indeed, S. 3205, proposed last year, provided that quality control results were to provide the basis for the normative error rate.

Second, although the language of § 1911(a) refers to error rates regarding incorrect denials of medicaid, it should be noted that the current medicaid quality control program does *not* require the review of denials and terminations of medicaid. In response to a pending federal lawsuit, *WROAC v. Mathews*,⁴ HEW has published proposed regulations to restore negative case action reviews to the medicaid and AFDC Quality Control programs. 41 Fed. Reg. 55727-29 (December 22, 1976). Final regulations have not yet been published, although it appears that HEW does intend to publish such final regulations in the near future. Thus, present HEW policy does not require the states to determine error rates in actions which are adverse to recipients. Accordingly, the Subcommittee should be aware that the specific provision in § 1911(a) for determining the error rates in medicaid denial cases at a future date is necessary since there is no recent data whatsoever on error rates in medicaid denials. As suggested above, the bill should specify that the error rates will be determined on the basis of statistically reliable quality control case reviews. The effect of § 1911(a) would thus be to mandate quality control reviews of medicaid denials and terminations, in the event that HEW does not follow through with its announced plans to reinstate negative actions reviews in the quality control programs.

With respect to the normative error rates we also have some general comments. We believe that the normative standard of acceptable error adopted by Congress should not be a static one, as is the standard in § 1911, but should be revised periodically to take into account improvements in state determinations

³ The proposed amendments to § 1903(n)(1)(B) and § 1902(a)(38) appear to contain inadvertent drafting errors. First, both sections refer to the normative error rate in § 1911(b). However, the standard for the Secretary's determination of the normative error rate is found in subsection (c) of proposed § 1911(e). Second, proposed § 1902(a)(38) requires the states to provide that their eligibility error rates for determinations subsequent to October 1, 1977 shall not exceed the rate established by § 1911(b) [sic]. The language of § 1911(a), however, makes clear that the normative rate will not be established by October 1, 1977. We presume this result is not intended.

⁴ On April 6, 1973, HEW discontinued, without public notice in the Federal Register, its long standing practice of requiring state quality control programs to review not only positive actions (i.e. cases on the assistance rolls) but also negative case actions (denials or terminations). On that date it eliminated negative case actions from AFDC quality control and suspended in its entirety the Medicaid Quality Control program. In July 1975 HEW reinstated the requirement for a medicaid quality control program, but consistent with its April 6, 1973 decision, negative case action reviews are not included. The elimination of negative case action reviews from AFDC and medicaid quality control was challenged in a lawsuit filed in the District of Columbia Federal Court by NWRO and local affiliate groups. *WROAC v. Mathews*. HEW has advised the District Court in *WROAC* that it intends to restore negative case action reviews to the AFDC and medicaid quality control programs.

expected as a result of the rigorous provisions of S. 1470. Lax federal supervision to date by HEW has resulted in very high error rates.⁵ Rather than require the states to attain only a level of efficiency that is represented by the standards established by the Secretary shortly after S. 1470 is enacted, Congress ought to require the states to achieve a new average level of efficiency each year, as such efficiency improves to more tolerable levels.

Proposed § 1911 should be amended to require an annual publication by HEW of state error rates for the preceeding year, and § 1911 and § 1902(a) (38) should require the states to achieve the "improved" error rate. At some point, of course, it is conceivable that state improvement will be so dramatic that the majority of states will have reduced their error rates to an unreduceable minimum. To account for this possibility S. 1470 could be amended to provide that if the Secretary, by regulation and after empirical analysis and study, should establish a minimally acceptable error rate below which improvement cannot be reasonably expected, any state meeting that rate would be deemed to be in compliance with § 1902(a) (38).

SECTION 32 (A) (1) : REGULATIONS OF THE SECRETARY

This provision would amend § 1102 of the Social Security Act, the section governing HEW rulemaking powers applicable to all HEW programs under the Act, not just medicare and medicaid. The provision was described upon its introduction in the Senate as being intended to require HEW to afford the public a minimum of 60 days in which to submit comments on proposed regulations, except for those which are urgent.⁶ While we are pleased that some of the serious problems with the predecessor to this provision in last year's bill, S. 3205, have been eliminated, we nonetheless believe that for several reasons this provision should be struck from the bill.

Our objections to § 32(a) (1) may be summarized as follows:

(1) Section 32(a) (1) is not drafted so as to accomplish its stated purpose, and as drafted it accomplishes a purpose that is contrary to the intent behind the proposal. In any event, as drafted, § 32(a) (1) is not needed in light of current law.

(2) The need for improvement in federal agency rulemaking procedures does not only apply to HEW rules, but is generally applicable to all agencies. Bills making such improvements applicable to all agencies, and addressing a wider scope of issues than this provision of S. 1470, are presently being actively considered by the House Judiciary Committee. This Committee should not circumvent the process now underway to comprehensively address the rulemaking process.

(3) Finally, since S. 1470 is a lengthy and complex bill primarily designed to improve health care financing and administration, consideration of any change in HEW rulemaking beyond the matters specifically covered by the subject of the bill should be undertaken in separate legislation. This would give the Committee, the Congress, and the interested public the opportunity to give the proposed changes in agency wide rulemaking procedures the careful consideration they deserve.

Each of these reasons for dropping § 32(a) (1) (including one suggestion for improvement if retained) are discussed more fully below.

1. *Objectives of the provision.* Section 32(a) provides that all HEW notices of proposed rulemaking under § 1102 must indicate whether the prompt promulgation of a rule is "urgent." If so, § 32(a) provides that "the rule or regulation shall become effective within sixty days after publication of the notice." With respect to rules not declared to be "urgent" this special procedure would not be applicable, and the rule would become effective "in the manner prescribed by applicable provisions of law."

As the language of § 32(a) (1) indicates on its face, and despite its sponsor's stated purpose, there is no specific mandate in the provision requiring that in non-urgent cases the public be given 60 days in which to comment. The only reference in § 32(a) (1) to "60 days" is a limitation on HEW, which requires the agency to

⁵ See, e.g. HEW Press Release, April 29, 1977 (HEW-HS4) concerning Medicaid Quality Control data for October 1975-March 1976.

⁶ See 123 Cong. Rec. S. 7204 (Daily ed. May 5, 1977) (Summary of S. 1470 offered by Sen. Talmadge).

make effective within 60 days those rules deemed to be "urgent." In sharp contrast, § 7(b) (1) of S. 3205, the predecessor provision to § 32(a) (1), required that where a notice of proposed rulemaking failed to indicate urgency, the rule could not become effective in "less than sixty days after publication of such notice." Unlike the present proposal, such language thus would have required a minimum period to elapse before effectiveness of a rule, thus, at least in theory, giving the public time to comment in that period.⁷

Further, the portion of § 32(a) (1) that requires "applicable provisions of law" to be the legal guide for non-urgent rules also does not have the effect of prescribing in a minimum 60 day comment period. Indeed, that provision would permit HEW to afford as short a period as 15 days within which public comments on a proposed rule would be accepted (and even a shorter period in some circumstances.)

Thus, the informal rulemaking provisions of the Administrative Procedure Act provide for the publication in the Federal Register of a general notice of proposed rulemaking, 5 U.S.C. § 553(b), and the solicitation and consideration of comments by interested persons, § 553(c), but they do not provide for any minimum period of time within which public comments may be submitted. Further, the Federal Register Act, applicable to informal rulemaking in the absence of specific statutory requirements, provides only that any notice in the Federal Register of an "opportunity to be heard" must be published "not less than 15 days" in advance of the deadline for being heard. Even that minimum time period can be reduced "where the shorter period is reasonable." 44 U.S.C. § 1508.⁸

If § 32(a) is redrafted to better accomplish its avowed purpose to provide a minimum time for receipt of comments, we strongly urge that the approach taken in S. 3205 last should not be used. This approach, as noted above, was a requirement delaying the effective date of proposed rules. It is crucial to a meaningful opportunity to be heard that the sound distinction made in the Administrative Procedure Act between the publication of proposed rules, § 553(b), and the publication of final rules, § 553(d), be maintained, and that no Congressional authorization be given for making effective a proposed rule in any given time period, however lengthy it may be.

Under the APA, proposed rules must be published not only to afford interested persons an opportunity to comment on the proposed rules, but also to oblige the agency to consider the comments submitted, and to reevaluate its original proposal in light of the suggestions or arguments made. It is only after such consideration that the agency may publish its final rule, with an effective date not less than 30 days following such final publication. That final rule must be published together with a concise statement of the basis and purpose of the rule and the agency's resolution of the issues raised by the public comments, 5 U.S.C. § 553(d).

If, however, any revised bill follows the approach of S. 3205, and authorizes the effectiveness of a proposed rule within 60 days, HEW could construe the provision as authorizing it or requiring it to condense the entire process of publication, receipt of comments, evaluation of comments, and finalization of the rule, into that 60 day time frame. Such a construction would necessarily give the public considerably less time in which to prepare and submit comments than the 60 day period, and thus would not only be contrary to the stated purpose of both S. 3205 and S. 1470, but would reduce the time presently provided by HEW for submission of comments on proposed rules. See 41 Fed. Reg. 34811 (Aug. 17, 1976), establishing a 45 day comment period.

⁷ We say "in theory" because, as discussed below, we do not believe that a minimum comment period on proposed rules may be achieved as a practical matter by legislation delaying the effective date of final rules, the approach taken in S. 3205.

⁸ In addition, since § 32(a) (1) applies only to publications in the Federal Register "in compliance with requirements imposed by law," it is arguable that this new provision will not bind HEW at all since its Social Security Act rulemaking function pertains to grants, benefits and contracts, and is therefore exempt from the requirement in the APA that rules be published in proposed form for public comment. See 5 U.S.C. § 553(a) (2). While HEW has voluntarily adopted the recommendation of the Administrative Conference that it follow APA rulemaking procedures, it may be argued that the publication of proposed rules by HEW is not pursuant to "requirements imposed by law." In any event unless Congress acts to remove the exemption specifically with regard to HEW rulemaking, or more generally acts to repeal the exemption, HEW could always revoke its voluntary adherence to the APA rulemaking provisions.

Indeed, in the case of many or even most regulations, some advance notice of the effectiveness of final rules adopted by the agency after comments, such as the minimum 30 day period now required by § 553(d) of the APA, would be needed by state agencies, providers, and beneficiaries, to provide a fair opportunity to adjust to new legal requirements. In those cases HEW might well construe the provision as authorizing a further limitation on the time for submission of public comments in order to accommodate this practical need.

While we urge below that the Committee should not include any general rule-making provision in this bill, if one is included for the purpose of increasing the time for public comment, that provision should specifically require that "the period for public comment afforded by the APA in § 553(b) shall not be less than 60 days." Such a provision would unambiguously satisfy the objective of S. 1470, and would increase the comment period presently afforded by HEW.

The wide margin by which § 32(a) fails in accomplishing the purpose ascribed to it indicates that perhaps there is some other goal intended to be accomplished. One such objective which the language of the proposal strongly suggests is a desire to restrict HEW's discretion with respect to the time within which HEW regulations shall become effective. Thus, 32(a) requires that rules designated by HEW as "urgent" "shall become effective within 60 days," and makes no allowance for possible exceptions.

If this is indeed the sponsor's intent, § 32(a) is at best unnecessary, and, at worst, a serious threat to responsible HEW reevaluation of its tentative rule-making proposals. First, when any agency subject to the APA determines that the usual notice and comment procedures are "impracticable" or "contrary to the public interest," 5 U.S.C. § 553(b), standards which clearly would include an urgent need to issue rules promptly, that agency is empowered to dispense with such procedures, or shorten the applicable time period for comments. All that is required to utilize this exception to usual time limitations is that the agency's reason for the urgency must be disclosed in the publication of the rule in the Federal Register. Thus, further discretion to issue "urgent" rules "within 60 days" is not needed by HEW.

On the other hand, even when an agency has good cause to shortcut the comment process because of an urgent need for prompt regulations, that alternative is often chosen because of a deliberate desire to obtain sufficient time for the agency to evaluate substantial arguments expected to be generated by a controversial proposal. If the agency is under a statutory constraint to make the rule effective in 60 days, regardless of the seriousness of the issues raised by the public, and regardless of the need for reevaluation of tentative agency positions, the natural effect of the statute will be to discourage reasoned, objective, and impartial consideration of public comments in so-called "urgent" cases. This problem will be exacerbated by paragraph (b) of § 32, which will require HEW to issue all regulations "necessary or appropriate" to implement amendments made by S. 1470 within 1 year, a virtual guarantee of the public's exclusion from meaningful participation in the process given the number and complexity of the regulations that will be needed and the automatic 60 day effectiveness provision.⁹

2. *Circumvention of general rulemaking reform.* Quite apart from the particular defects in draftsmanship, in our view it would be a serious mistake for the Committee to report legislation dealing with the general rulemaking power of HEW at the same time that several bills are now pending in the Congress which are receiving serious consideration, and which would enact comprehensive reforms of the rulemaking provisions of the Administrative Procedure Act.¹⁰ For example, one such bill, H.R. 116, would completely revise § 553, the provision pertaining to proposed rulemaking. Introduced in January by Rep. Flowers, Chairman of the Administrative Law and Government Relations Subcommittee of the House Judiciary Committee, it is virtually identical to the bill unanimously reported out of the full Judiciary Committee last year (H.R. 12080). Last year's bill

⁹ Indeed, the inclusion of paragraphs (a) and (b) in the same provision strongly indicates the sponsors' intent to pressure HEW into implementing the Act without real public participation. By requiring all rules to be issued in one year, the bill virtually requires the agency to designate all implementing rules as "urgent," thereby triggering the mandatory 60 day effective date provision.

¹⁰ See, e.g., H.R. 116, H.R. 901.

failed to receive consideration in the House largely because of the press of other business at the end of the session, but in light of its derivation and history it is likely that H.R. 116 will be seriously considered this year.

If enacted, H.R. 116 would substantially revise the informal rulemaking provisions of the Administrative Procedure Act to accomplish, *inter alia*, the following objectives relevant to this subcommittee's concerns.

1. It would subject HEW's medicaid rulemaking to the requirements of the APA by virtue of the repeal of the statutory exemption for "public property, loans, grants, benefits, or contracts."

2. It would require more rigorous agency efforts to inform members of the public likely to be affected by regulations that they have been proposed, thereby facilitating and encouraging the expression of views that would otherwise not be represented.

3. It would require that agencies use § 553 notice and comment procedures in adopting interpretive rules and general statements of policy. The § 553 exemption for such rulemaking would be repealed.

4. It would provide a minimum 45 days for public comment. While this is shorter than the 60 day period purportedly required by S. 1470, the 45 day requirement would be most effective if enacted with other provisions of H.R. 116 that require greater specificity in the notice of proposed rulemaking as to the agency's "purpose" in rulemaking, and a full disclosure of the technical or other factual data upon which the agency relied, and stricter requirements for providing reasoned responses in the final publication to issues raised by public comments.

5. Finally, H.R. 116 would establish an elaborate procedure for Congressional review of all agency rules, with the power to veto rules which are unsatisfactory to either House of Congress.

While we do not necessarily agree with each of the provisions of H.R. 116, we do believe that Congress should have an opportunity to consider the broader questions raised in connection with federal agency rulemaking before this committee tackles the issues in a particularized context of a single agency, and in connection with a bill targeted on complex and important program reforms in two specific HEW programs. Surely any systematic and concerted effort to improve Federal rulemaking, an effort consistent with the President's own often expressed desires, would be jeopardized if all other "substantive" committees of the Congress began independent consideration of, or actually enacted, major revisions to the rulemaking procedures used by the particular agencies or in the specific programs over which they exercise legislative or oversight responsibilities.

3. *This bill is the wrong vehicle to deal with HEW rulemaking.* If special attention to HEW rulemaking by this Committee is believed to be necessary despite the pendency of several APA reform bills, we strongly urge that such consideration be given in a separate bill, not in S. 1470 where it is overshadowed by very substantial, complex and controversial medicare and medicaid amendments, on which Congress' and the public's attention will be focused. While it is undoubtedly true that there are some problems with HEW rulemaking that would justify the Committee's attention, these problems apply to social security, SSI, and AFDC as well as medicare and medicaid, and the entire range of issues should be explored deliberately, and undiluted by the important health financing issues addressed by S. 1470.

SECTION 43: WAIVER OF HUMAN EXPERIMENTATION PROVISION FOR MEDICARE AND MEDICAID

The exact purpose of this provision is not clear but it does suggest a possible waiver of existing human experimentation protections. We submit that any waiver of human experimentation protections is contrary to both the interests of recipients and the broad public interest in sound and responsible governmental research.

The human experimentation provisions that currently apply to programs established under Titles XVIII and XIX of the Social Security Act apply only to research, that is, project activities within the programs in which requirements imposed will subject the recipients to procedures which are different from those which generally prevail in the programs. These provisions apply only where there is use of a procedure for research purpose which is a departure from "established methods necessary to meet [the subject's] needs, or which increases

the ordinary risks of daily life". Thus, these protections come into play only in those situations where a particular requirement or condition is being imposed for the very purpose of determining what its effect will be, and there can be no better evidence than this purpose itself of the need to exercise maximum care to attempt to avoid injury to the project participants. Surely neither these individuals nor society as a whole is well served by any provision which would increase the risk to them or obscure the full facts as to the effect of the requirement.

Moreover, the existing human experimentation protections do not impose any insurperable barrier to responsible project activities. They require only that there be an evaluation of the risk to the participants and that appropriate protections be utilized where risk is found to exist. A project is totally barred only if it is found that the potential risk so far outweighs the possible benefit to be gained from undertaking the research that there can be no justification for such research. Clearly this conclusion is the only decision that could appropriately be made under such circumstances in any government sponsored research.

Furthermore there can be no question that the proponent of the project activity receives the fullest and fairest hearing on this issue. The decision as to the existence of risk is made by a review board appointed by the project applicant itself. Certainly there can be no claim of undue "Washington interference" where the board that conducts the review and makes the decision consists of those very people whom the project applicant has determined have the knowledge and background to evaluate the project and weight its risk and benefits.

As can be seen from this brief description of the framework of the human experimentation protections, they establish no more than the minimum of what any responsible researcher would be expected to do in fairness to both those directly involved in the research and the general public that is asked to support such research. Indeed, there has been criticism of the existing protections as not going far enough to provide fully adequate protection. Whether or not the protections should be made even stronger, there certainly can be no warrant for reducing them in any way. Even a suggestion that the aged, disabled, and needy Americans who rely on the medicare and medicaid programs to obtain desperately needy health care should receive less than the protection accorded to all others could cause incalculable damage.

The need for the full continuance of the existing human experimentation provisions has been fully documented by the intensive study of this issue which has been carried on by the former Committee on Labor and Public Welfare Subcommittee on Health (now the Committee on Human Resources Subcommittee on Health and Science Research). Indeed it seems wasteful if not sheer foolishness to even consider a change of this magnitude without calling upon the resources and special expertise of that Subcommittee which has been intimately involved with the development of the federal human experimentation protection provisions.

In sum, we would recommend that this provision should be totally eliminated from this bill in recognition of the ever present need for vigilance against harm accruing from ill-conceived, ill-designed and/or maladministered research. We further submit that to the extent that the proponents of this provision have particular concern with the implementation of the human experimentation provisions of Public Law 93-348, these concerns would be far better addressed by referring these problems to the Subcommittee on Health and Science Research of the Committee on Human Resources which has direct responsibility for the development of these matters. This would assure that whatever is done will have the benefit of being considered in the overall context of human experimentation protections and in the light of the comprehensive understanding of this matter which that Subcommittee has developed.

SECTION 45 : TRANSFER OF PROPERTY

This section provides that a state will not be penalized by loss of federal funds if it denies medical assistance to individuals who would be ineligible for such assistance if, in determining such individual's eligibility for Title XVI benefits, there were included in his/her resources any property owned within the preceding twelve months that was given or sold to a relative for less than its fair market value. We assume that this provision is intended to prevent elderly persons from transferring substantial assets to family members in order to qualify for medicaid benefits. We have several comments.

1. We do not believe there is any evidence that such transfers of property are at all common. HEW has indicated in correspondence provided us that it does

not have information as to frequency of such transfers. Surely the eligibility determination process should not be encumbered by unnecessary additional criteria.

2. If the provision is to remain in the bill, it should be revised to apply only where the transfer was made for the purpose of establishing eligibility for medicaid benefits. The bill as written would deny medicaid to persons making gifts to members of their family even if such gifts were made at a point in time when application for medicaid benefits had not even been contemplated. It would also deny eligibility when the transferor simply made a bad deal, had no choice but to sell the property for less than its fair market value, or was swindled of the property. Cases like these frequently occur particularly with respect to the elderly.

3. Only a person's equity in property may be counted as a resource to determine eligibility for medicaid benefits, since that is the amount of money the person could obtain to meet the cost of medical care by selling the property. Since section 45 may be read to require attribution of an amount greater than the person could have received by selling the property for full market value less the encumbrance on the property, the section should be clarified so that only the equities in the property, at most, will be attributed.

By the same token, the provision should not provide for an attribution of the value of the transferred resource to the person so long as the person received fair compensation for the value of his/her equity in the property. As currently drafted, a person who sells encumbered property to a relative for an amount in excess of his/her equity, but less than fair market value, and therefore makes a profit on the transaction, would nonetheless have the value of the property attributed to him/her as a resource.

In sum, if the transfer of property provision is to be retained, it should (1) call for an attribution of resources which have been transferred only when the transfer was made solely for the purpose of qualifying for medicaid benefits, and (2) the value of the resource so attributed should be clearly specified as the person's equity in the property, less the amount of compensation received for the property.

STATEMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

(By Jan Peter Ozga¹)

The Chamber of Commerce of the United States welcomes this opportunity to present its views on S. 1470, the "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1977." Our membership of more than 68,000 business firms, trade and professional associations, and local chambers of commerce shares with the Congress a deep concern over the rising cost of hospital and other health services, which are paid by Medicare and Medicaid as well as private health insurance plans.

In general, the National Chamber favors the approach to administrative and reimbursement reform contained in S. 1470. The bill represents a significant step in the right direction; and, with certain modifications, it could be an important factor in helping to solve some of our health care cost problems.

Before proceeding with our analysis of and positions on selected provisions of S. 1470, it might be helpful for committee members to learn about business' understanding of the health cost problem and employers' stake in this issue. After we have addressed S. 1470, we will include some examples of action taken by employers to help curb health costs, as well as some specific cost-savings activities in which the National Chamber is engaged.

PROBLEM: HEALTH CARE COSTS

According to the Social Security Administration, last year nearly \$140 billion was spent on personal health care services, over 40 percent of which went toward hospital bills. The average hospital stay now cost \$1,300, up a whopping 1,000 percent since 1950 compared to a 236 percent increase in consumer prices as a whole. The Council on Wage and Price Stability reports that the two largest increases over the past quarter century occurred between 1976-71, after the

¹ Associate Director—Health Care, Economic Security, Education and Manpower Section Chamber of Commerce of the United States.

implementation of Medicare and Medicaid, and between 1974 and 1975, soon after the Economic Stabilization program (during 1971-1974) ended. These figures underscore the inflationary effect which governmental programs and price controls have had on health care.

Last year more than \$33 billion was spent on Medicare and Medicaid, far exceeding the original estimates when these public health programs were enacted over a decade ago. Of this amount, \$25 billion—over 75 percent—was for claims covering hospital charges.

Over 90 percent of all hospital charges are paid by someone other than the patient, usually through public or private insurance programs. It is no wonder then that very few persons feel the full impact of rising health care costs—increasing at an annual rate of 15 percent—and that attempts to educate consumers to make more cost-saving decisions regarding their health care have not been successful.

There are a number of reasons for escalating health care costs. These include: overall inflation; the cost of complying with governmental regulations; the growth of our population, coupled with expanded health care benefits and increased demand for services; malpractice awards and protection (and related factors such as over-prescribing and overtesting); and heavy investment in new technology. However, accelerating the rise of health care costs are the expense of public health programs such as Medicare and Medicaid and a 30% rise in such costs within two years when Phase IV of the wage and price controls were lifted from the health care industry in 1974.

BUSINESS ROLE IN HEALTH CARE

The cost of current health-related benefits to business is 25 times higher than it was a quarter of a century ago. Whereas in 1950, less than half of all wage and salary earners had hospitalization, surgical and regular medical coverage, the vast majority of workers now have such coverage.

Between 1965 and 1976, while wages rose about 85 percent, health-related benefit costs increased over 200 percent. According to the Rand Corporation, approximately 80 percent of some \$33 billion in private health insurance premiums are paid through employment related plans, with employers paying an average of two-thirds of these costs, making business the largest purchaser of health care services.

These rising health care costs have caused some health experts to advocate extensive government controls of the health care industry. The National Chamber disavows with this approach and recommends instead an approach along the lines indicated in a recent assessment by Clark C. Havighurst, Professor of Law, Duke University. Prof. Havighurst, in discussing the role of competition in cost containment, stated that he would still "value the market mechanism highly and allow it a prominent part, not only because it can contain costs and force the system to give value for money, but also because it preserves consumers' and providers' opportunity to express their other values and preferences . . ."

The Chamber's specific policy on "Efficiency and Control of Costs," which was adopted through a referendum of our organization members, follows:

EFFICIENCY AND CONTROL OF COSTS

Business should encourage:

1. All hospitals, extended care and nursing home facilities to adopt uniform accounting practices, financial reporting and cost-finding systems;
2. All hospitals to establish arrangements to review and monitor (peer review) the appropriateness of such items as hospital admissions, duration of stay, and treatment prescribed;
3. All hospitals, extended care and nursing home facilities to accept reimbursement for services on a prospective, rather than on a retroactive ("cost-plus") basis, with budgets, financial statements, statistics and services to be reviewed by private and public payers;
4. Physicians to accept reimbursement for "usual and customary charges" as payment in full for services rendered;
5. Each hospital to charge the same prices for the same services, regardless of the kind of benefit protection of the patient;

6. The provision of effective peer and utilization review of all inpatient and outpatient health services.

Employee benefit programs should :

1. Be broadened to encourage health care in the least expensive manner ; and
2. Require deductibles and co-payment for services received, where feasible.

THE TALMADGE BILL (S. 1470)

S. 1470, the "Medicare and Medicaid Reimbursement and Administrative Reform Act of 1977," represents a significant step in the right direction to help curb rising health care costs. The bill envisions instituting reform in the practices of hospitals, physicians, nursing homes, and in the administration of Medicare and Medicaid and related public health programs.

Hospital reform

The National Chamber supports in general S. 1470's cost-saving concept of establishing prospective limits on reimbursable per diem operating costs. This approach should help provide necessary incentives to hospitals to become more cost-efficient.

This concept of reform is good, necessary, and valid: a textbook ideal approach. A realistic approach would outline a broad plan rather than set out specific solutions as this bill attempts in certain areas. The bill's most basic flaw is that it is the crude beginning of a federally centralized rate setting system. Serious questions arise as to whether rate setting, with all its constraints on health care delivery resources will curb spiralling health care costs, correct fraud and abuse of the Medicare/Medicaid program and have an overall positive effect on the health care system.

Although S. 1470's incentive reimbursement system is a better method of controlling costs than the price ceiling on inpatient charges proposed by the Administration's "Hospital Cost Containment Act," we cannot entirely endorse this provision since as drafted it does not effectively include *all* third-party payors. Public health cost-savings should not be made at private expense. In earlier testimony before the Congress, for example, a hospital association has admitted that losses in revenue resulting from public reimbursement policy are compensated by increasing charges to private payors, such as Blue Cross, commercial insurers or patients.

When introducing S. 1470, Senator Talmadge stated that he was "quite open to the idea" of broadening his proposal to reach beyond Medicare and Medicaid. This bill appears to reflect his intentions, with provisions such as "the (reimbursement) system applies to all revenue sources for hospitals within the State;" and, further, hospitals must "not agree to increase amounts due from any individual organization or agency in order to offset reductions," resulting from Medicare and Medicaid reimbursement policies. However, S. 1470 does not define how such a discriminatory transfer of costs will be averted.

Therefore, the National Chamber recommends that S. 1470 be expanded to include both public and private third party payors, so that public savings will not be made at private sector expense.

The National Chamber also supports S. 1470's provision for uniform accounting among hospitals to help provide a basis for cost-saving actions. However, because of the diversity among hospitals and other health care facilities, we recommend that this reform bill also include uniform financial reporting and standardized cost-finding systems, with sufficient flexibility to accommodate different management practices.

Another area of cost-savings which S. 1470 does not address, but which the National Chamber finds worthy of serious consideration, is energy savings. It has been estimated that hospitals and nursing homes could save as much as 20 percent on the cost of energy without using capital investment funds just by initiating more efficient energy practices. Using capital investments to purchase energy saving devices, energy savings could be as high as 40 percent.

Another cost-saving technique which has shown evidence of success is budget or rate review, as now practiced in several states. Such states—one of which initiated this system on a voluntary basis—are exhibiting cost-savings which

equal or exceed the objectives set by S. 1470 and other related legislation. Clearly, rate review is another cost containment option which should be included in S. 1470. In fact, 20 percent of all hospitals with similar programs are holding cost increases to nine percent or less.

The National Chamber also supports S. 1470's attempts to control capital expenditures by extending and expanding the authority of health planning statutes. These include responsible decisions made by project review under Section 1122 of P.L. 92-603 and Section 1526 under P.L. 93-641, as well as State Certificates of Need. We also favor the principle that decisions on capital expenditures in metropolitan areas which cross state lines should include input from states in which the metro area is located. Projects which are disallowed by local and state health planning authorities should not receive Medicare or Medicaid reimbursement for costs associated with rejected projects.

Finally, the National Chamber urges the Committee to consider recommendations made by certain health provider and insurer groups advocating inclusion of other cost-savings innovations in S. 1470. These include incentives for group purchasing, shared services, consumer education, peer and utilization review (including second opinions on surgery decisions), and health care economic courses in medical schools and hospitals. Generally, attempts should be made to study institutions which have implemented one or more of these cost-saving procedures and to determine if they should be utilized more widely.

Administrative reform

Among the major administrative reforms in S. 1470 is the creation of the Health Care Financing Administration, which consolidates into one agency four related public health programs: Medicare, Medicaid, Office of Long-Term Care, and Bureau of Quality Assurance.

The National Chamber recognizes the need for better coordination and administration of these public health programs. Although HCFA has already been created through administrative action taken by the Secretary of Health, Education, and Welfare, we share Senator Talmadge's concern that this new agency should not increase the bureaucracy. However, we fail to see how S. 1470 will prevent this.

S. 1470 advocates the abolition of the Health Insurance Benefits Advisory Council (HIBAC). We oppose this provision. HIBAC enables valuable private sector opinion—including high level management expertise—to become part of public policy. Eliminating this advisory body would remove an important dimension in helping to administer Medicare and Medicaid. If S. 1470 is expanded to include all insurers, the retention of HIBAC becomes even more essential to the concept of public-private collaboration. Therefore, S. 1470 should retain HIBAC or at least replace this body with a suitable counterpart.

Finally, the National Chamber supports S. 1470's provision to reduce or eliminate fraud and abuse in public health programs. These include S. 1470's provision that claims will be denied to persons falsifying Medicaid eligibility by transferring temporarily their property to relatives or friends.

BUSINESS ROLE IN CONTROLLING COSTS

Recognizing that controlling health care costs should not be a unilateral effort, but rather a partnership of private and public endeavors, the business community has been expanding its role in helping to curb rising health care costs. Among a number of examples which could be cited are:

"The Phoenix Experience," in which a prominent manufacturer in the Phoenix area collaborated with several hospitals to help keep their costs down. This collaboration was facilitated by the local health planning agency, which acted as an intermediary in helping to identify specific high cost areas within these hospitals. The result of this collaboration was a number of recommendations, which, when implemented, led to an immediate reduction in hospital costs and improved communication among the hospitals.

In Akron, Ohio businessmen serving on health project review teams were instrumental in saving nearly \$80 million by disallowing several unnecessary hospital projects.

Business works in other ways to reduce health care costs through the provision of preventive health services. A survey recently conducted by a major tire manufacturer of some 80 companies, with from 5,000 to 100,000 employees, revealed that the following services were offered:

Services offered:	<i>Percent of companies offering service</i>
Pre-placement physical examination-----	96
Environmental health examination-----	75
Promotion examination-----	33
Overseas examination-----	77
Management physical examination-----	82
Treatment of occupational conditions-----	91
Medical counseling-----	82
Limited treatment of nonoccupational conditions-----	87
Physical conditioning for management-----	26

The National Chamber Foundation is embarking on a study to develop a "National Health Care Strategy." A paramount feature of this study will be recommendations for controlling health care costs that can be utilized by business firms in any community.

Finally, the National Chamber presented a strategy to the Council on Wage and Price Stability last year that businessmen could enact to contain health care costs in advance of legislatively created programs. This strategy is contained in Attachment A.

CONCLUSION

The National Chamber supports S. 1470 as a significant step in the right direction toward controlling health care costs. The bill's administrative and reimbursement reforms appear to offer incentives to the health care industry to become more cost-efficient and effective. However, we favor broadening the coverage of S. 1470 to include both private and public third party payors, so that public savings will not be made at private sector expense. Also, we support the retention of the Health Insurance Benefits Advisory Council, to enable private sector opinion to become part of public health policy.

In sum, the National Chamber holds that cost-saving proposals should encourage competition and provide well-designed incentives which allow the nation's health industry to operate at its optimum. We further recommend flexibility to allow for innovation, so that our health care system can better serve the American people.

ATTACHMENT A

BUSINESS STRATEGY FOR HEALTH CARE COST CONTAINMENT

(Source: Excerpted from "The Problem of Rising Health Care Costs," a statement by the Chamber of Commerce of the United States before the Council on Wage and Price Stability, October 28, 1976.)

First, the National Chamber and individual business leaders are encouraging participation by businessmen in health planning agencies being established as a result of the Health Planning and Resources Development Act of 1974. These agencies have the responsibility for developing a health plan for communities and reviewing proposed expenditures by health facilities for capital improvements. Any unnecessary projects would be denied.

Second, businessmen are encouraged to give enlightened service while serving on the boards of hospitals as hospitals trustees. Business must work with hospitals to develop cost-finding systems and hospital reimbursement formulas which provide incentives to hospitals to hold down costs. Prospective reimbursement, and other experimental payment mechanisms should be implemented where feasible.

Local hospital overbedding results in unnecessary costs, either through overutilization of hospital services in an effort to keep the beds occupied or through the costs of carrying the empty beds. The problem of hospital overbedding can be controlled by hospital boards, planning agencies, Blue Cross Boards, and State "Certificate of Need" legislation.

Reimbursement formulas for services of hospital-based physicians (i.e. radiologists, pathologists) should assure that such services are not overutilized and unnecessary.

The building or purchasing of expensive but rarely-used facilities or equipment should be carefully controlled; i.e., brain scan equipment, cobalt therapy machines, and open heart surgery units should not proliferate to satisfy the "keep up with the Joneses" syndrome.

Effective utilization and peer review mechanisms should be developed to prevent unnecessary hospital usage. Hospitals in a given area should work toward increased use of shared facilities to avoid duplication of costs where possible.

Third, by working with Blue Cross, Blue Shield and insurance carriers, businessmen can investigate the type of initiatives that could control health costs. Individual benefit plan designs can be altered to deemphasize expensive hospital-based care and encourage the use of simple surgical procedures at outpatient surgical facilities, and preventive care measures.

Plan designs should incorporate simplified and effective co-insurance and deductibles to motivate consumers to buy care more prudently. Business can investigate and publicize the cost and service performance of local providers so consumers can make informed decisions. Presurgical screening and second medical opinions should be encouraged where possible and cost-effective. Employee benefit plans should be designed to control health costs with an emphasis on the reimbursement of health care providers, benefit utilization, eligibility and administration.

Fourth, Health Maintenance Organizations (HMO's) which represent another potential for reducing health care costs have been expanding as a result of Federal legislation that supports their development. Employers should promote the availability of alternate competitive types of health care delivery, such as HMOs. HMOs represent a major attempt to restructure the health delivery system. Unlike the fragmented fee-for-service system, HMO's provide both inpatient and ambulatory care within one organizational structure. The financial interdependence of physicians and hospitals eliminates the incentives for physicians to over-prescribe more costly inpatient hospital services. Evidence exists that significant reductions in hospital utilization have been achieved as a direct result of HMO-type medical care management. Last year alone, the average premium for HMOs increased only half as fast as traditional insurance indemnity plans or Blue Cross and Blue Shield plans.

Fifth, businessmen can and should work toward the removal of restrictive state laws or regulations which limit the flexibility of providers or carriers in implementing new and innovative health care ideas. These include a host of subjects such as HMOs, medical professional liability insurance, certificate of need legislation, etc.

STATEMENT OF THE COMMITTEE FOR A FEDERAL HEALTH BANK

We would like to address our remarks to the question of degree to which Medicare-Medicaid reforms should be expanded. Although we are in favor of the reforms, we feel the scope of the Medicare and Medicaid programs should not be expanded at this time.

The Administration has promised a national health program early next year. It would seem wise if today's legislation were integrated with the broader legislation to come. If next years' legislation uses a different approach to health problems, there would probably be a great deal of duplication and overlapping of services and coverage.

Our understanding is that the only approach to health care programs being considered is one that involves taking dollars from the population as a tax and attempting to return those dollars in the form of health benefits. We are opposed to this approach, because there is a better way to do it. We advocate placing health dollars as a deposit, not a tax, into a Federal agency, which then takes on the role of a bank. This fundamental difference from the conventional approach must receive your thoughtful attention. Important benefits in the form of interest free loans would be available to all participants who make deposits into the bank. These loans to cover routine health expenses, and major-medical insurance as proposed by Long & Ribicoff to cover extra-ordinary expenses, preclude the need for any other federal health plan except for those people without income. The new Medicare-Medicaid law that emerges should be limited to this group of people. The time you gain by a smaller bill can be well spent studying the many pro-

posals, including this one, that will hopefully bring better health care to the young and middle-aged who represent the largest segment of our population by far.

A condensed outline of the Federal Health Bank plan is included as part of this testimony, and more details of the plan are available from the committee for a Federal Health Bank. We urge the health sub-committee to initiate its own study of the Federal Health Bank concept immediately. To short-change yourselves on knowledge of this promising concept would be a great disservice to the American people.

THE ANSWER TO OUR HEALTH PROBLEMS—A FEDERAL HEALTH BANK

Total health care for everyone with no rise in taxes is a goal that can be reached today with appropriate legislation. It would require the creation of a Federal Health Bank integrated with major medical insurance as proposed by Long and Ribicoff. The bank should be non-political with directors appointed by the President and confirmed by the Congress.

The health bank would provide coverage for every person with income and who files a tax return. Those with zero income would be the group for whom existing welfare and medicare programs should be left intact. For all others, whatever the source of their income, monies would be channeled into the bank through the existing withholding system. This concept is widely advocated by health economists with one major difference. They envision the money taken in the form of a tax. By making the money a deposit with ownership intact, instead of a tax, a flood of benefits accrue. First of all, most people will not object to a forced deposit as much as to a tax.

Secondly, an army of government bureaucrats is not needed to administer the return of health benefits. Each person decides exactly how his own health dollars are to be spent. He alone decides what insurance to buy in addition to his major medical, what doctors to visit, what treatment to accept and he draws funds against his account to meet those needs. He is, in effect, administering his own health plan free of cost.

This is very much like the system in use now except that a Federal Health Bank offers a solution when health needs exceed bank balances.

Negative balances, or interest free loans, are available through the considerable new resources generated by the bank. The negative balances will be limited by the deductible amount of the depositors' major medical insurance, which is expected to be around \$1,500.

NEW RESOURCES GENERATED BY THE BANK

The committee advocates chartering the bank so as to permit the investment of idle funds solely in government securities. This will generate approximately \$8 billion a year. Since the bank would, in effect, be providing a collection service to the doctors and to avoid criticism of "a doctors' give-a-way" the bank should deduct a modest fee of 3 to 4 percent from drafts submitted by doctors for payment. This would generate another \$6 billion for a total of \$14 billion of new health dollars. Other systems develop nothing except additional expense. In addition to these considerable benefits of the health bank, there are three strong forces brought to bear against rising health costs.

One is the natural inclination to spend more judiciously when it's your own money. Patients will always look for the least expensive treatment that will do the job. This is the exact opposite of what occurs with the other system; furthermore, government waste will be less with a smaller type of agency.

Secondly, the providers will have the knowledge that their fees might come under the scrutiny of the bank's computer system. There will be a natural desire by doctors to avoid being singled out for charging excessive fees.

Thirdly, the advantages of adequate financing will work in the area of Blue Cross-Blue Shield coverage. Premiums will be reduced because the need for coverage will be limited to those expenses not covered by the major medical. In addition, with interest-free financing available patients will tend to buy less comprehensive policies since they now have the means to meet more routine type of expenses.

All these forces, automatically brought into being by the formation of a Federal Health Bank, will result in a positive and significant reduction of soaring health costs. This, coupled with the large scope of coverage and the improved efficiency

in the entire delivery system, makes the health bank approach to health care the only sensible approach.

The bank directors will constantly monitor the flow of monies and make the adjustments required to keep the bank operating on a sound financial basis . . . similar to the way the governors of the Federal Reserve system control the cost of bank borrowing.

In summary, we have presented the basis for a health plan that leaves intact all of our existing institutions. The plan places the Federal government in the familiar role of collecting and dispersing large sums of money. By allowing patients and doctors to direct that flow of money, within limits set by the banks' directors, a system emerges that is more comprehensive and efficient than with any other national health plan. Providers and insurance companies will have to make some minor adjustments but their basic operations will remain the same. There will be less government interference than with other national health schemes. Providers and insurance companies will enjoy higher levels of activity and patients will have more of their treatment needs satisfied.

Many details have been omitted from this outline. The function of the committee for a Federal Health Bank is to either provide those details or assist in their development.

STATEMENT OF HAROLD E. GASPAR, M.D., P.A.

GENTLEMEN: My name is Harold Gaspar. I am a physician practicing anesthesiology in Dallas, Texas and have practiced in this field for almost 20 years. Upon consultation, I provide professional care to each of my patients individually on a fee-for-service basis, as is the prevailing practice in my community. I am in my 16th year as a Diplomate of the American Board of Anesthesiology and as a Fellow of the American College of Anesthesiologists.

I strongly disagree with certain of the provisions of Sections 12 and 15 of S. 1470 relating to the practice of anesthesiology and the use of relative value schedules. Several other anesthesiologists located in the State of Texas, whose names follow, have authorized me to convey to you their concurrence and approval of the ideas expressed in my written testimony:

Dr. George Beck of Lubbock, Tex.; and
 Dr. Carlos Botty,
 Dr. Donovan Campbell,
 Dr. Charles A. Cohen,
 Dr. George Emmett,
 Dr. Gordon I. Goldstein,
 Dr. Charles Maimbourg,
 Dr. Shirley A. Moore,
 Dr. James M. Morgan,
 Dr. Marvin J. Noble,
 Dr. Rupert M. Pollard (also Attorney-at-Law),
 Dr. Pedro Vidal,
 Dr. George Weaber,
 Dr. Oscar B. Williams, Jr., all of Dallas, Tex.

Some of these physicians, specifically Doctors Botty, Campbell, Cohen, Goldstein, Maimbourg, Moore, Noble, Vidal and Williams, have written directly to Senate members of the Subcommittee on Health, and I enclose copies of their letters as Attachment 1 of this statement.

We physicians appreciate the necessary and important work of your subcommittee in seeking to contain the costs of government-provided health care and hospital and practitioner reimbursement. We wish to see every American gain access to the best possible medical care at a price which is *fair* for the service provided. We object, however, to Section 12 of S. 1470, which is entitled Hospital Associated Physicians and includes provisions dealing specifically with anesthesiology services.

Under Section 12(a)(2) anesthesiologists may be deemed to have "personally performed" a procedure in stipulated instances and may be fully reimbursed accordingly where more than one patient is being treated at the same time and where persons other than the physician anesthesiologist may perform certain services. In our view, such a system does not provide for optimum and, in some cases, even adequate medical care. We agree with that portion of the

statement given before this subcommittee on June 10, 1977 by the American Society of Anesthesiologists that "there is no substitute for the one-to-one relationship between anesthesiologist and patient." We strenuously object to Congress' placing a stamp of approval on a system which allows provisions of services in a less than optimal fashion. We believe it is wrong to reimburse anesthesiologists who perform several anesthetic procedures or who supervise nurses providing anesthetic services on different patients at the same time, as if these services had each personally been performed by the physician.

We also object to Section 15 of the proposed legislation which authorizes the Secretary of Health, Education and Welfare to establish and publish relative value schedules because:

(1) The adoption of such schedules requires large numbers of physicians to develop a consensus about details of a proposed schedule (unit value, time units, relative values for risk factors, and what constitutes a risk factor, among other things) and, in essence, to collude in fixing prices in a manner which destroys the competitive nature of the medical profession and decreases the options and variety available to the consuming public.

(2) The adoption by HEW of relative value schedules will exert considerable pressure on all physicians to price their services in accordance with the schedules regardless of the desire or ability of individual physicians to be more or less cost-efficient, productive, or to establish fair prices based on the uniqueness of individual practices.

(3) The collusion and price fixing which is inherent in the adoption of a relative value schedule can easily be misused and abused by the various actors participating in our Federal health care financing programs, and would contribute to excessive costs for inferior health care delivery.

I will now elaborate on some of the further reasons why each of the sections described above should be carefully reviewed by the Subcommittee.

SECTION 12

Several questions are raised by Section 12 of S. 1470 as it pertains to the delivery of anesthesiology services. What is the optimum standard of care in anesthesiology practice? Should the Congress of the United States put its stamp of approval on a standard of care which is less than optimum? Should physicians be deemed to have "personally performed" services for government reimbursement purposes which were actually delivered by non-physicians? And, finally, what right does the consumer patient have to know and to choose who will provide anesthesiology care and the conditions under which it shall be provided?

To illustrate some of the dimensions of these questions, I ask each of you to imagine the following simple scenario. Your family physician advises you that you should have your gall bladder removed. He recommends that you see Dr. X, a surgeon, about the operation. Dr. X confirms your doctors' diagnosis and schedules a date and time for your surgery at Saint Mary's, your nearby hospital. On the appointed day and time, you arrive at the hospital and, eventually, you are wheeled into the operating room where Dr. X and several other individuals are preparing for your operation.

One of these individuals, dressed in a hospital uniform, has your charts and requests certain information from you. Another individual, sounding quite authoritative, places a mask over your nose and instructs you to breathe deeply and count slowly from 100 to 0. You are now anesthetized and ready for the operation.

Little do you know that the individual who has conducted the preanesthetic evaluation, a physician, may delegate the remainder of the anesthesia procedure for this generally routine operation to the second individual, a non-physician, who has some training in anesthetics. The physician may leave the operating room to supervise the activities of three other non-physicians involving three other patients as well as engage personally in the more demanding aspects of a procedure on one of the patients, all while your operation is proceeding. According to S. 1470, that physician, though not present in the operating room, will be deemed to have "personally performed" your anesthesiology services for government reimbursement purposes, though he has had no direct contact with you after his preanesthetic evaluation.

To continue the scenario, during the course of this routine operation, you develop some respiratory or circulatory problem. Assume that the non-physician anesthetist is incapable of diagnosing the problem, or diagnoses the problem after so much time has elapsed or makes an error in diagnosis. Or, assume that the non-physician anesthetist correctly diagnoses the complication in a timely fashion, and relays the information to the responsible anesthesiologist, but the anesthesiologist is not free to attend to the problem for several minutes due to complications in the anesthesia procedure being administered to a patient for which he is in direct charge, or due to his supervisory responsibilities for other non-physician anesthetists and possible concurrent responsibilities for three other patients. In any of the above circumstances, you may suffer grave and irreversible consequences and even death that could have been avoided if the physician had in fact personally performed the anesthesia service instead of being merely deemed by law to have done so.

Analysis of this scenario suggests several answers to the questions raised above. The optimum standard of care is clearly one physician caring and responsible for one patient at a time. In fact, a strong argument can be made that merely adequate anesthesiological services, rather than the optimal, require such a standard of care. Leaving patients in the hands of technicians and non-physicians, who may one day be called upon to make life-or-death decisions, is not medically desirable. My colleagues and I recognize that anesthesiologists cannot today meet all patient needs without the assistance of nurses and technicians. What we are suggesting, both as physicians and taxpayers, is that the government should pay physicians a fair price for only those services which the physician has actually rendered. No physician should be deemed to have personally performed a service under circumstances in which he is not actually responsible for, and able to respond to, the needs of his patient.

Lest our simple scenario be dismissed as an overdramatization, I call your attention to two recent studies which seem to verify the need for encouraging higher standards of anesthesia care. Dr. Jeffrey B. Cooper of the Massachusetts General Hospital in Boston reported to the 1976 American Society of Anesthesiologists annual meeting in San Francisco, that in his study of some 96 cases of anesthesia mishaps or near mishaps, 67 were caused by human error and only 9 by equipment failure. Of the 67 mishaps due to human error, fully 30 percent of the anesthetists were determined to be inadequately trained or to possess inadequate experience. A second study focused on cardiac arrests during surgery and was based on 41 malpractice suits occurring during routine surgical procedures. The chief causes of the arrests were hypoxia and hyperventilation, conditions clearly within the domain of the anesthesia specialty, and not the surgical specialties.*

Section 12 not only would provide Congressional approval for substandard anesthesiological care, it would provide an economic disincentive to the provision of adequate or optimum services. Indeed, what physician would be foolish enough to care for only one patient at a time when he could "spread" his services by utilizing nurses and technicians while billing each patient as though he had personally provided for his care (which even the patient, as we have seen in our scenario, might think is true). In its present form, S. 1470 would create an intolerable financial burden on those anesthesiologists who desire to provide optimum, one-to-one care, and in the long run would encourage inferior services at a higher cost to our society. Physicians who serve essentially an administrative function by supervising non-physicians, rather than actually delivering anesthetic service themselves, deserve to be reimbursed, perhaps by some type of consultation fee arrangement. The objectionable feature of Section 12 is that it seeks to reimburse physicians for administrative and supervisory services on the same basis as if they had actually directly administered anesthesia services to the patient.

The Senate Subcommittee should be aware of several other shortcomings of Section 12.

By not clearly and accurately defining the types and qualities of anesthesia available, but by promoting the notion that anesthetic care can be de-

*See Taylor, G., Larson, P. and Prestwick, R. "Unexpected Cardiac Arrests During Anesthesia and Surgery: An Environmental Study" in the *Journal of the American Medical Association*, Vol. 236, pp. 2758-2760, December 1976.

livered just as well by non-physicians who are directed by physicians as by the physician himself, the patient-consumer is misled and denied the right to make an informed judgment in selecting his anesthetic care. We believe that patients under Medicare should be viewed by the Senate as a class of persons, who have paid their insurance premiums, and have contracted with the government to reimburse physicians for providing optimum medical services.

By encouraging anesthesiologists to direct their talents and energy into administration rather than the direct provision of medical care to a single patient, Section 12, if enacted in its present form, will definitely exacerbate an already severe problem in our hospitals. Even today some hospitals have entered into contractual arrangements with small groups of anesthesiologists which essentially tie the availability of hospital services to the provision of anesthesiology services by hospital-employed nurses. Patients who find themselves in these hospitals are denied the choice of their own anesthesiologist and, instead, often must rely on the inferior level of care which Section 12 sanctions. Not only will the further encouragement of such arrangements result in a serious lowering of the standards of anesthesiology services available to the consuming public, this indirect form of anesthesiology services also constitutes an unnecessarily heavy financial burden on the health care system through double billing for the same service. The United States Government would be reimbursing, under Part B, the anesthesiologist for merely supervising care provided by a nurse, and the United States also would be paying a second time for this same service by reimbursing hospitals under Part A.

The current exploitation of nurses and technicians by some hospitals and/or anesthesiologists will likely continue in the event that this legislation is enacted. Without endorsing their specific recommendations, we concur with that portion of the statement of the American Association of Nurse Anesthetists delivered to this subcommittee on June 10, 1977 which calls for greater fairness and equity in the reimbursement levels to the various parties involved in anesthesia care.

The proposed legislation does not provide a rationale for why anesthesiologists should be labeled "hospital associated physicians" and why physicians in other specialties are not so identified. I do not consider myself to be a "hospital associated physician" any more than I consider those surgeons who are not hospital employees, yet call me in consultation and utilize hospital facilities, to be "hospital associated."

In summary, my colleagues and I wish to see the Congress modify Section 12 so that it provides for reimbursement only for services actually rendered, and endorses and creates economic incentives which will enhance the possibilities for physicians to deliver the best care available to the patient.

SECTION 15

As a physician, I object to being forced to utilize a specific price-fixing scheme such as the proposed Relative Value Schedule authorized by Section 15. There are times when an individual physician may find it useful, as a management procedure or tool, to compare his own various charges for different procedures and to develop time units and relative values for risk factors associated with different procedures. Such use of a relative value schedule on an individual basis to achieve management efficiency and price rationalization is a far cry from the use of RVS permitted in this legislation.

Utilizing the RVS methodology to arrive at the customary and prevailing charge levels in a community would require absolute agreement on every detail of a proposed schedule, from the nature of units to the relative value of units and risk factors. To achieve such agreement, some doctors would be compelled to become unwilling participants in collusive pricing activity properly forbidden by our antitrust laws.

I would ask that you consider my right to set my fees on an idiosyncratic basis and ask that you refrain from forcing me into a price-fixing scheme by mandatory use of the RVS. As a taxpayer, I protest the imposition by Congress of a system of coordinated and coercive price fixing that can be expected to increase the cost of medical services to the Federal Government and to private individuals.

In my opinion, Congress' original concept of reimbursing physicians on the basis of the customary and prevailing charge in the community has great merit. Through careful and intelligent administration of such a system, the purchaser

of medical services is protected from being overcharged by the physician, who cannot be reimbursed for more than his customary rate for a delineated service nor reimbursed for more than the prevailing rate determined for the locality. The free enterprise nature of the medical profession is not detrimentally impeded by such a system; it does not preclude a variety of services at different costs, and it allows the consumer to exercise choice among doctors and providers, and among qualities and costs of services rendered.

In addition to the price increases and lack of consumer choice that traditionally have been associated with price fixing, the lumping together of many different kinds of services into a single RVS category could be expected to prove more costly than would the "customary and prevailing charge" method, which permits more precise descriptions of the service actually rendered and allows for more accountability in reimbursement. I understand, indeed, that it is the past abuses associated with relative value schedule use which has led your subcommittee to reexamine Medicare and Medicaid reimbursement procedures.

The potential for abuse inherent in the use of such schedules is exacerbated when they are used by physicians to justify reimbursement for anesthetic services rendered in full or in part by non-physicians. The proposed legislation would permit the anesthesiologist, who may have merely supervised or is technically responsible for the rendering of the anesthetic services, to charge a set fee established in a RVS as if he had personally performed the service on the patient himself. We believe that the lack of specificity in S. 1470 about what constitutes adequate supervision, and the likelihood of total delegation of anesthetic functions to non-physicians in many hospital settings, will contribute to significant cost excesses in these government programs.

Section 15 of the bill would appear to authorize physicians to hold meetings and concertedly to agree on Relative Value Schedules for recommendation to the Secretary of HEW and, subsequent to adoption of these Schedules by HEW, to use these RVS in their own price-setting. By enacting S. 1470, Congress would be authorizing a practice that the Federal Trade Commission has on four occasions in the past year attacked as illegal and anticompetitive.¹ Indeed, the Justice Department has charged that the current use of relative value schedules is a felony.²

It is quite clear that incorporation of the Relative Value Schedule mechanism in S. 1470 was welcomed by the representatives of the American Society of Anesthesiologists as a means of responding to the lawsuit against the ASA by the Justice Department. My colleagues and I were disappointed to learn that no representatives of the FTC or Justice Department made presentations before the four-day public hearings concerning this legislation of the Subcommittee on Health on June 7 through 10, 1977 to detail the reasons for their agency positions.

Gentlemen, the agencies responsible for enforcing the antitrust laws have charged that the concerted adoption of Relative Value Schedules is price fixing. Under the antitrust laws, my colleagues and I understand from consulting with our attorneys of the Washington law firm of Covington & Burling that any agreement that tampers with prices—even by stabilizing or lowering them—is illegal.³ If nothing else, it is clear that the use of Relative Value Schedules will at least "stabilize" prices. We believe that RVS's have in fact been used nationwide to raise prices rather than to lower them, and that the proposed "HEW Approved" scales would be used to create even greater pricing rigidity and higher prices in the future.

¹ Minnesota State Medical Ass'n, 3 Trade Reg. Rep. (CCH) ¶ 21,294 (FTC, announced April 20, 1977); The American College of Radiology, 3 Trade Reg. Rep. (CCH) ¶ 21,236 (FTC 1977); The American College of Obstetricians and Gynecologists, and The American Academy of Orthopaedic Surgeons, 3 Trade Reg. Rep. (CCH) ¶ 21,171 (FTC 1976).

² United States v. The American Society of Anesthesiologists, No. 75 CIV 4640 (S.D.N.Y., filed Sept. 22, 1975). While this is a civil action, it charges that the concerted adoption and promulgation of a Relative Value Guide is a "contract, combination . . . or conspiracy or restraint in trade or commerce" in violation of Section 1 of the Sherman Act, 15 U.S.C.A. § 1 (Supp. 1977). In 1974 the Congress made violation of this Section a felony. Pub. L. No. 93-528, 88 Stat. 1706.

³ See United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 221 (1940): "Any combination which tampers with price structures is engaged in an unlawful activity. Even though the members of the price-fixing group were in no position to control the market, to the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces. The [Sherman] Act places all such schemes beyond the pale and protects that vital part of our economy against any degree of interference."

In S. 1470, Congress would take the extraordinary step of legislatively attempting to reverse an order of the Federal Trade Commission and to nullify a current action before a United States District Court. We are not convinced that the worthy purposes of S. 1470 justify so drastic an action, and we firmly believe that the means employed by S. 1470 will do more harm than good.

Thank you for your patience and diligent attention in consideration of these matters.

ATTACHMENT 1

LETTERS FROM INDIVIDUAL ANESTHESIOLOGISTS TO MEMBERS OF THE SENATE SUBCOMMITTEE ON HEALTH

JUNE 20, 1977.

HON. HERMAN E. TALMADGE,
Chairman, Senate Committee on Finance-Subcommittee on Health,
Republican Senate Office Building,
Washington, D.C.

Dear Senator Talmadge: This is to inform you of our opposition to Senate Bill 1470 concerning treatment of reimbursement for anesthesiologists. We are opposed to anesthesiologists being paid more for supervision of ancillary personnel than for anesthesiologists providing optimal care on a one to one basis. We do not feel that anesthesiologists should be reimbursed on a Relative Value Guide. This has been a means used by physicians to defraud the government for services that they have not actually rendered in the past. We appreciate your concern for equity in payment both to the patient and the physician and your concern for the taxpayer's money.

Sincerely,

CARLOS BOTTY.
Suite 608
Dallas, Texas 75231
PEDRO VIDAL.

DALLAS, TEX., June 2, 1977.

SENATE COMMITTEE ON FINANCE,
Subcommittee on Health,
Washington, D.C.

GENTLEMEN: My name is Donovan Campbell, I am 54 years old and a native of the State of Texas. My education consists of a Bachelor's degree in Economics, a Master's degree in Philosophy and a Doctor's degree in Medicine. I am a Diplomat of the American Board of Anesthesiology and a Fellow of the American College of Anesthesiology. My post-graduate training was done at Charity Hospital and I was certified in 1960. Since 1957 I have been engaged in the practice of anesthesiology. In the interest of fairness and in the interest of establishing truth and fact the following is respectfully submitted.

Senate Bill 1470, a bill to provide for the reform of reimbursement procedures currently employed under the Medicare Program, contains Section 12—Hospital Associated Physicians. This Section deals with reimbursement of physicians who render anesthetic services. The present bill provides for full payment to a physician for in essence the administration of two simultaneous anesthetic procedures. It also provides for partial payment when a physician with others acting for him performs two or more anesthetic procedures at the same time. This is a very serious matter and one which deserves careful consideration. The following is submitted for your consideration.

In the last ten years the face of surgery has changed. Patients coming to elective surgery today for the most part have diseases in other organ systems which complicate not only the surgical procedure but the anesthetic procedure and the postoperative course. The greater danger these patients face is anesthesia. Such patients during surgery and anesthesia undergo abrupt changes in the blood pressure, pulse rate and other physiologic parameters which truthfully and in fact make it impossible for one physician to render anesthetic care to more than one patient at one time. Those who have proposed to the Committee that reimbursement be made for such action have for the most part been motivated mainly by the monetary aspect. When such a situation exists then one or both of the patients or all of the patients who are supposedly under the simultaneous care of one physician and who are paying the physician for his services are in essence

being defrauded, for almost without exception the patient has been assured that the physician will attend him. This action has repercussions not only for the patient but also for the medical community. Without going into detail it should be mentioned that in at least two large cities and in many small towns in Texas anesthesiologists are currently billing and receiving payment for doing four or five anesthetic procedures at the same time. Some of these are being paid under the Medicare Program and evidence to this effect can be found through access to the records at Blue Cross and Blue Shield which is the local carrier for the Medicare Health Insurance in Texas. Further evidence for this type of practice could be obtained if one had access to the hospital records and to the surgical and anesthetic records. Practices such as these not only lower the standard of medical care for the patient and put the patient at great risk during surgery but they actively discourage other qualified physicians from coming into such areas and cities to practice the specialty of anesthesiology. This in turn discourages bright young people from going into the specialty of anesthesiology and ultimately provides and provokes a shortage of people in the field. Thus the concept of paying a physician in anesthesia for two or more anesthetic procedures conducted at the same time is a practice which leads to a number of undesirable ends. It in effect pays an individual for medical care which he does not render. Thus the system promotes fraud and at the same time it prevents the patient having access to other qualified individuals because this practice effectively prevents the influx of anesthesiologists into these areas.

Thus it is strongly recommended that the Medicare system not pay a physician for doing or providing care for more than one patient at one time.

Section 15 of Senate Bill 1470 gives tacit approval to the use of a relative value guide or schedule. This has been a bone of contention for years among physicians and in the past a number of physicians have colluded with third party carriers, including carriers who are approved to act for the Social Security Administration in payment of Medicare benefits, to violate Federal Antitrust Laws with regard to collusion and fee-fixing. The concept of payment to a physician for his services under the usual, customary and reasonable terminology which was established earlier has been eminently successful and is eminently acceptable to the great majority of physicians. It is furthermore easy to establish the usual and customary charges by the use of statistical data and provides no real problem for any insurance carrier in terms of reimbursing the physician or the patient who has a contract with the insurance carrier.

In the past the collusion which has existed between various societies and officers of various societies throughout the United States along with insurance carriers and third parties has resulted in antitrust suits and actions taken by the Federal Trade Commission. These actions in the estimation of a great number of physicians are soundly based, fair, reasonable and designed both by the Justice Department and the Federal Trade Commission to put an end to the collusive activity which has occurred in the past. It is the submission of this individual that the substitution of a relative value guide for the system now in effect would compound the problem of price fixing by giving it tacit approval.

Those who have proposed the use of a guide and payment for multiple simultaneous procedures have assured the Committee that this would lower the cost of medical care. This is patently untrue. Costs under a system using a relative value guide are solely a function of the conversion factor. If this factor is set by professional groups who have been exempted from antitrust action, you may be sure it will be costly. If it is set by agencies using charge data already in existence then there is duplication and reduplication of effort. Why take charge data from which a usual, customary and reasonable charge has been computed and artificially create another cumbersome charge system? Finally with payment based on any method for two or more simultaneous procedures the patient or the insurance carrier is paying more and more for less and less.

The question which must be present in your minds—Why then should the National Society advocate this?—requires at least a simple answer. Those who represented to the Committee that Sections 12 and 15 are desirable as well as beneficial are those who have benefited financially from utilizing this system. They are also the persons who over the years have been in political control of our professional societies. To give you a simple example, the Texas State Society has for a period of five years, through its nominating committee, appointed the same six persons to hold all the seats on its Board of Directors. Thus six people have held 30 seats for five years and have dictated policy. The mass has had no

voice. And of ultimate importance these six have either carried out the practice of simultaneous procedures or for political plums have supported those who do. Finally a relative value guide is a necessity for these people for they bill patients whom they never see and never attend by having the technician who carries out the procedure fill out a card. This card is then handed to a secretary who utilizes the *guide* to compute a medical fee. The guide, then, becomes a tool by which the patient is billed for a service which the physician has not delivered. Very attractive for Doctors who gain from it, but ultimately providing less medical care at a greater price and actively discouraging physicians from entering the most vital and important of medical and surgical specialties.

Respectfully,

DONOVAN CAMPBELL, M.D.

CHARLES A. COHEN, M. D., Assoc.,
Dallas, Tex., June 16, 1977.

HON. LLOYD BENTSEN OF TEXAS,
Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BENTSEN: I am Dr. Charles Cohen, engaged in the private practice of anesthesiology in Dallas, Tex. This letter is being sent to your committee regarding proposed legislation of anesthesiologists' fees and methods of practices. I hope that this committee, after reading my testimony and that of other anesthesiologists who directly care for their patients, will amend this proposed legislation to distinguish between services provided by the anesthesiologist, and those provided by nurses (or others) under the supervision of an anesthesiologist.

The proposed legislation reimburses a physician's charge for his anesthetic equally, whether he is in constant attendance or merely supervising others giving the anesthetic. It seems to me that there is a marked difference in the level of care given a patient when a board-certified specialist is in constant attendance rather than when he is just in the area and available for the handling of problems when they arise. The ultimate in anesthetic care ought to be the administration of each and every anesthetic in this country by a board-certified anesthesiologist. It is true that most anesthetics do not require a physician and may be administered by a less well-trained person but if a complication should arise, however, an anesthesiologist's presence is vital: indeed it may even prevent complications. There are many planners of health care that might argue that it is not necessary for a physician to administer every anesthetic, usually a routine, uncomplicated procedure. Non-physicians do provide these services at a lower cost. An analogy: Most cases of labor and delivery are routine, can be managed by a mid-wife, and do not require the constant attention of an obstetrician; but in those instances where complications do arise the presence of the obstetrician is necessary for the well-being of the patient. Therefore, the patient pays a higher fee for the obstetrician to be at every delivery, however routine they may seem, so that he will be there for those cases where his attendance is crucial. So it is with the anesthesiologist. The present legislation seems, if anything, to discourage physicians from going into anesthesia and, therefore, increases the opportunities of possible complications of anesthesia without the expertise of the board-certified specialist. The mortality and morbidity resulting from anesthesia can be as high or higher than that of the surgical procedure itself. It is somewhat paradoxical that in spite of this, there is a major effort by health planners to decrease physician contact with patients during anesthesia.

Much of the information given to this committee has been given by anesthesiologists who employ nurses and/or supervise the training of residents; these physicians would benefit from the proposed legislation. I do not believe a full picture has been given of the role played by the solo practitioner of anesthesia, or of the anesthesiology group, each of whom administers the anesthetic personally and is in attendance during the entire case. A careful preoperative evaluation allows the anesthesiologist to learn about the patient's medical and surgical problems, current medications, past anesthetic history, and psychological status. Ideally, a thorough preoperative evaluation would anticipate and, therefore, avoid many intraoperative problems. The anesthesiologist who is caring for one patient at a time is in a better position to fully evaluate each patient than the anesthesiologist who is supervising two or more nurse anesthetists and has to hurriedly see all of the patients preoperatively. This is one very important benefit to the patient of physician-administered anesthesia. The same holds true

for management of post-operative problems. The proposed legislation discourages anesthesiologists from taking care of patients on a one-to-one basis and makes it very likely that they will hire nurse anesthetists to work for them because they will make significantly more money doing so.

Concerning the relative value guide and its use in this proposed reimbursement procedure: It seems that again the information given to this committee has been largely from people who benefit financially from using the guide because they do not have to identify *who* provides the anesthesia services. The relative value guide has been used not as a guide but as an absolute standard for reimbursement by third party carriers, including Medicare. Several of us in Dallas, have tried and been successful in showing the Bureau of Health Insurance that the Medicare law now in existence already provides for the usual, customary, and reasonable reimbursement of physician services. It does not provide for the arbitrary use of the relative value by the United States Government in determining anesthesiology fees. Anesthesiologists in Texas are now paid on the basis of usual, customary, and reasonable fee as are other physicians in Texas. I would strongly urge this committee to recognize that anesthesiologists are physicians and, therefore, should be reimbursed on the same basis as other physicians. Perhaps the relative value guide may be used in the case of physicians who employ nurse anesthetists, or residents, and do not provide the service themselves. I do not think that *all* anesthesiologists should be reimbursed under the arbitrary relative value guide. I would suggest to the committee that we anesthesiologists who practice medicine by ourselves, and in constant attendance of patients, wish to be treated as physicians and not as employers of technicians.

Thank you for your consideration.

Sincerely yours,

CHARLES A. COHEN, M.D.

DALLAS, TEX., June 17, 1977.

HON. LLOYD BENTSEN,
*Republican Senate Office Building,
Washington, D.C.*

DEAR SENATOR BENTSEN: I am a consultant in anesthesiology and I have been a practicing physician in Dallas, Texas, for the past twelve years. I would appreciate if you would indulge a few minutes of your time and allow me to express my concern about some of the provisions of Senate bill 1470.

I am in total disagreement with Section 12 of this bill. My practice is devoted to taking care of one patient at a time. This bill will provide anesthesiologists who supervise technicians double reimbursement for less than optimal care. It would also allow the hospital to bill under Part-A Medicare if the technicians are hired by the hospital. I feel this is unfair to the taxpayer and unfair to the physician providing optimum care. It will put Senate approval on a fraudulent medical practice where the patient will not be aware if he or she is being cared for by a technician or a physician and the patient will be billed as if a physician has rendered the service. This in no way will control costs. It will give a monopoly to anesthesiologists supervising technicians and will prevent competition in the marketplace besides discouraging optimal care. I feel the best possible care can be rendered on a one doctor to one patient ratio.

Dr. Ahmet, President of the American Society of Anesthesiologists, has requested that your committee reimburse certain services under the provisions of the original Medicare Law; e.g. customary and prevailing, and other services be reimbursed according to the Relative Value Guide. Anesthesiologists should not receive special consideration under the law and should be reimbursed in accordance with the provisions of the customary and prevailing concept. The Relative Value Guide allows certain anesthesiologists easy access to the government pocketbook without having to make any explanation for their services. The fraudulent practice of many anesthesiologists as protected by the American Society of Anesthesiologists should be stopped! The Relative Value Guide has been a price-fixing mechanism since its inception and has been challenged by the Justice Department and the Attorney General. The Attorney General has said that his number one priority is to stop price-fixing because, "it is anti-competitive and unAmerican." I would hope the Senate would support his views.

I do not feel that I am a hospital-associated physician anymore than my colleagues the internists and the surgeons. Perhaps if the Senate would require anesthesiologists to be accountable for their services and charges as are other physicians, the quality of care would be greatly improved.

Very truly yours,

GORDON I. GOLDSTEIN, M.D.

[Mailgram]

DALLAS, TEX., June 17, 1977.

SENATE COMMITTEE ON FINANCE, SUBCOMMITTEE ON HEALTH.

GENTLEMEN: My name is Charles Maimbourg, I am 43 years old and full time practicing anaesthesiologist and a fellow of the American College of Anaesthesiology since 1960 and Board Certified Anaesthesiologist since 1966. I have been doing full time private practice of anaesthesiology since 1963 in Dallas, Texas.

The following relates to Senate Bill 1470, Section 12: Optimal care can be provided on a 1-1 basis—one patient to one anaesthesiologist. This section deals with reimbursement of a physician for administration of 2 simultaneous anaesthetic procedures. This practice would be less than optimal care for the patient. This type situation being practiced today has caused inferior care in many localities and this practice has been carried on by anaesthesiologists being paid under the Medicare program. In some localities they are billing and receiving payment for doing 4 or 5 anaesthetic procedures at the same time.

I strongly recommend that the medicare system not pay a physician for doing or providing care for more than one patient at a time. The following relates to Senate Bill 1470, Section 15: Section 15 gives tacit approval to the use of a relative value guide or schedule. This has been a bone of contention for years among physicians in the past, a number of other physicians have colluded with third party carriers, including carriers who are proved to act for the Social Security Administration in payment of Medicare benefits, to violate Federal antitrust laws with regard to collusion and fee-fixing.

I strongly support the concept of payments to a physician for his services under the usual, customary and reasonable terminology which was established earlier and has been eminently successful and is eminently acceptable to the great majority of physicians.

CHARLES L. MAIMBOURG, M.D.

MOORE & ASSOCIATES,
Dallas, Tex., June 17, 1977.

Re: Senate bill 1470.

Senator HERMAN E. TALMADGE,
Senate Committee on Finance,
Subcommittee on Health,
Washington, D.C.

DEAR SENATOR TALMADGE: No matter how strongly you wish it and no matter how much testimony you may listen to, to the contrary, the fact remains that a nurse is not a doctor. As is the practice in the social welfare state. Senate Bill 1470 is a plan to equate all anesthetics administered and reduce them all to mediocrity. The optimal condition should be an Anesthesiologist administering an anesthetic to our patient and because the specialty of anesthesiology is becoming increasingly more demanding and more important in the operating room, more and more young physicians have been choosing this specialty in the recent past. If the desire of your Committee is to continue to encourage the highest quality of medical care for the Medicare patients, then you must see that Senate Bill 1470 is specifically designed to discourage this end.

Regarding the section of Senate Bill 1470 dealing with a Relative Value Guide, this is nothing but another ploy of Government to encourage monopoly and price fixing. An Anesthesiologist is a physician and should be considered under the present bill along with all other physicians who receive usual and customary fees. The computer can ascertain these fees just as easily for Anesthesiologists as it can for all other physicians.

My concern in this matter is very great as I am an Anesthesiologist who has been in the private practice of anesthesia for nine years in the city of Dallas, Texas. I have a Bachelor's Degree in Mathematics, a Master's Degree in Education and a Doctor's Degree in Medicine, and I am a Fellow of the American College of Anesthesiology. Because I believe that the ethical standards and high quality of the practice of anesthesiology, as well as the entire structure of our free enterprise system, would be jeopardized by Senate Bill 1470, I hope that your final decision will be to vote against this bill.

Yours very truly,

SHIRLEY A. MOORE, M.D.

MARVIN J. NOBLE, M.D., Assoc.,
Dallas, Tex., June 16, 1977.

HON. LLOYD BENTSEN of Texas,
Committee on Finance,
U.S. Senate, 240 RSOB.,
Washington, D.C.

DEAR SENATOR BENTSEN: I would like to draw your attention to a bill being reviewed by the Subcommittee on Health of the Senate Finance Committee. I refer to S. 1740. As a practicing anesthesiologist in Dallas who has been a Diplomate of the American Board of Anesthesiology for 10 years, I find this Bill to be in conflict with itself as well as with other actions of Congress.

Vast sums of federal money have been spent in writing legislation and now in trying to implement those laws to improve the quality of medical care afforded the American people. Section 12 of S. 1740 would be a step backward. I attend one patient at a time, whether I am in an operating room or in an intensive care room, or seeing someone who suffers chronically with pain. I cannot delegate my knowledge and physical skills and judgement to an assistant. I have had the experience of trying to do that.

For two years I served in the U.S. Army as an anesthesiologist and worked with nurse anesthetists. Although I was physically present, the care of the patient was more dependent on their moment to moment judgments. And, Senator, their education for making these judgements is less sophisticated than mine. I have also worked as a faculty member (full time) of a medical school. Again, I cannot provide the same service through an agent as he would if he did the task himself. Therefore, I ask, how can an anesthesiologist who "supervises" one or two nurse anesthetists be compensated at a full fee the way I would be if I anesthetize the patient myself?

One final thought about section 12 beginning with line 16 of page 31. I have seen many more difficulties during the administration of the anesthetic while the surgery is in progress than the outline of A) through F) might suggest. Several years ago a prominent university surgeon addressed the American College of Surgeons that when more than a local anesthetic is being used, there is no major or minor operation; there are only major or minor surgeons. I think that points to the need for more anesthetics to be administered personally by anesthesiologists and not by proxy. Compensation in full when supervising will not lead us to the goal of quality which is so frequently and loudly endorsed.

May I address the method of payment outlined at the beginning of the bill and also the "use of approved Relative Value Schedule" on page 37 line 21. First, if we are intent on providing care for those unfortunate people covered by Medicare and Medicaid, the provision of an all or none acceptance of assignment payment method will probably severely reduce the accessibility of medical care for them. If most physicians refuse to accept fee determination by the Medicare carrier, then these patients will have to look further for their care.

Secondly, I find the proposed use of a Relative Value Guide (RVG) to be unwise. I have seen it abused in Texas, especially by the Medicare intermediary. I know of its abuse in the Northeastern U.S. It quickly becomes a means of fee fixing and is an absolute restraint. The collusion which will evolve would make the OPEC oil pricing look amateur. And the ones establishing the RVG and its conversion dollar value would most likely be those who are hiring or supervising nurse anesthetists.

Although the usual, customary, and reasonable method of determining reimbursement has some deficiencies, it is certainly a more open market type of pricing. This is a statistical system in which no monopoly play can exist. In the American Society of Anesthesiologists' testimony of June 10, 1977, Dr. Ament said this system is satisfactory for determining non-operating anesthesiologists' charge, i.e., pain management, respiratory therapy. I do not see a need to have the insurance carrier have two systems of fee determination for 10,000 physicians. I do not see why we need a different system from other physicians. A RVG could be used for reference in a difficult determination, but it would destroy the multiple levels of charges now in existence. That is monopoly fee fixing.

I urge you to prevent these dollar abuses and to help us maintain a goal of quality in the practice of anesthesiology.

Sincerely yours,

MARVIN J. NOBLE, M.D.

DALLAS, TEX., June 17, 1977.

Hon. LLOYD BENTSON,
240 Republican Senate Office Building,
Washington, D.C.

DEAR SENATOR BENTSEN: At present Senate Bill 1470 is before your subcommittee on Health. There are two provisions in this bill to which I would like to voice my strong exception.

The first objection is to the use of a Relative Value Guide for reimbursement of anesthesiologists' charges. This concept results in the fixing of charges unrelated to the actual charges for services rendered. The opinion of the Federal Trade Commission regarding the use of such guides by professional groups is that its use represents a restraint of trade. The use of a guide tends to increase the monetary payment of services since there is no provision for competitive pricing. For reasons that are not apparent only anesthesiologists will be reimbursed by this means and all other physicians will be reimbursed by calculating the usual, customary and reasonable charges. In Texas all physicians are reimbursed by determining the usual, customary and reasonable charge for services rendered. I do not understand why this method should be changed or why anesthesiologists should be differentiated from other physicians in this matter.

The second objection is directed to the section which permits anesthesiologists to be reimbursed for supervising more than one simultaneous anesthesia equally in amount with the anesthesiologists who provide continuous care for one patient. I believe anyone would agree that optimal care for anesthetic management is one anesthesiologist providing care for one patient at a time. If the government is going to reimburse a physician as generously for supervision of non-physicians as for the optimal care of a patient I feel that there may be a tendency for physicians to acquire groups of non-physicians in their own pay and profit unreasonably from the government. The level of supervision could deteriorate and as such the quality of care equally deteriorate. Individuals providing optimal care would be encouraged by the prospects of financial gain to provide less than optimal care. In effect the government will be paying for a service that is not rendered in that a physician supervising four procedures would receive four times the amount of a physician providing care on a one to one basis.

The testimony of representative officers of the American Society of Anesthesiologists supports the law as now written and I can only question their motives. Surely they are not directed toward offering the highest quality of care for the patient.

I would appreciate very much hearing from your office regarding these matters. My interest is directed toward providing the finest care for the least amount of the taxpayers' money and discouraging fraud or abuse in the Medicare program.

Sincerely,

O. B. WILLIAMS, Jr., M.D.

HAWAII MEDICAL SERVICE ASSOCIATION,
Honolulu, Hawaii, June 3, 1977.

Re: S. 1470, The Medicare-Medicaid Administrative Reimbursement and Reform Act.

Hon. SPARK M. MATSUNAGA,
U.S. Senate,
362 Russell Senate Office Building,
Washington, D.C.

DEAR SENATOR MATSUNAGA: Thank you for providing us with a copy of S. 1470 and the opportunity to present these comments regarding this proposal.

The Hawaii Medical Service Association along with the doctors and hospitals in Hawaii are concerned about the continuing increases in the cost of medical care to the people of Hawaii. We are in support of this proposal to the extent that it will attempt to bring responsible cost containment to hospitals. We certainly support these efforts.

There are some aspects of this bill that are of concern to HMSA which we believe require further study and modification. The cost limitations in S. 1470 apply only to Medicare-Medicaid programs. While this will, of course, save

money for these two programs, the provision will simply cause hospitals to pass additional costs on to private sector programs such as HMSA. We strongly urge that any cost limitation program be applied to all classes of hospital patients.

Second, the bill sets cost limitations by bed size categories. Increase in future costs would be made based on the classification of hospital and geographic determinations. The exceptions in the bill may be sufficient to recognize Hawaii's unique situation but we are concerned as to whether Hawaii would be considered a separate geographic rate area and whether Hawaii's present level of service would be recognized as a cost differential. We presently experience an extremely short hospital length of stay in Hawaii which results in a high intensity of service per day. High intensity service results in high average cost per day. To average Hawaii's short stay per diem cost with longer length of stay geographic areas would be improper.

Thank you for the opportunity to present our views and if we can be of further assistance, please let us hear from you.

Sincerely yours,

ALBERT H. YUEN,
Executive Vice President.

STATEMENT OF THE HEALTH SYSTEM AGENCY OF SOUTHWESTERN PENNSYLVANIA
BY MATTHEW MARSHALL, JR., M.D., SECRETARY, BOARD OF DIRECTORS

I am Matthew Marshall, Jr., M.D., secretary of the board of directors of the health systems agency of Southwestern Pennsylvania, and a practicing physician. I am here to tell you that our board and our people are certainly most assuredly interested in health cost containment; but more importantly, we are interested in the best possible health and the best possible health care that the economy of our system will support.

The HSA offers these comments regarding capital cost containment:

A. We suggest strengthening of the provisions regarding capital expenditures based upon the following policy decisions approved by the board.

1. That the policy making role of HSA boards to decide issues such as capital construction requirements, occupancy rates, and supply of beds should be preserved and that these functions be continued as an integral part of the plan development process.

2. That it is appropriate to require HSA's to give consideration to the impact of debt service for capital construction on per diem costs and in developing their health services plan, but it is inappropriate for the Federal Government, State Government, or HSA's to set caps on a national, state or local basis.

3. That any debt service limits or requirements of locally contributed capital utilized by the HSA be applied only as guidelines rather than as policy position in order to assure flexibility for the HSA, and therefore, facilitate planning in the best interests of the community.

4. That with respect to assuring that federally financed health services are productive and not wasteful of tax dollars, the board felt that the HSA should receive periodic reports of the appropriateness of levels of care, effectiveness, and quality of care paid for by all federally financed programs. Information should be made available to the HSA's on a periodic basis in order that the HSA develop an adequate health systems plan. Also, it was agreed that aggregate information would be adequate so no breach of confidentiality of PSRO data would be required.

5. Reimbursement rate visibility should be encouraged as a stimulus for better community input to the health planning process, and that the mechanism for the obtaining of this visibility should be the concern of the Federal Government rather than the HSA, since detailed financial reporting is provided to the Federal Government.

B. We call to your attention that current legislation permits the Secretary to reject any proposal under 1122 that has been deemed inadequately reviewed by an HSA. The Secretary should be requested to document the extent to which he has exercised the authority which he has in this regard.

C. The Secretary has the responsibility to ensure that all health care programs supported by federal funds participate in the development of the health services plan and assure that their plans conform to the plan of the HSA, and we urge that he fully exercise his authority.

We appreciate the opportunity of presenting this testimony.

REPORT OF THE CAPITAL NEEDS STUDY COORDINATING COMMITTEE

The United States currently invests 8.3 percent of its Gross National Product in health care services. In 1975 the average per capita expenditure for health care was approximately \$550. As the price of health care services and the quantity of health care services used are increasing, many individuals including health policymakers are questioning the conventional thinking which has said that increasing expenditures to provide more health care will translate into better health.

Recognizing the difficult problems of containing health care costs while endeavoring to assure that health care services are of acceptable quality, accessible and adequate to meet demonstrated needs, the Board of Directors of the Comprehensive Health Planning Association of Western Pennsylvania, Inc. established the Health Facility Financing Study Coordinating Committee. The primary charge to the Coordinating Committee was to cooperate with the sponsors of the current study entitled "Financing Capital Improvements for Health Care Facilities in Southwestern Pennsylvania" and to recommend a course of action thereon to the Board of Directors of the Health Systems Agency of Southwestern Pennsylvania. This report is in line with that charge. Specifically, it addresses the problem of the cost of health care in Southwestern Pennsylvania and recommends an instrument for considering the economic consequences of capital expenditures in the health sector.

Health planning has paid particular attention to the development of realistic physical, environmental and operational standards for health care facilities. The impact of capital expenditures on health care costs has frequently been neglected or given only scant attention. However, as the cost factor is gaining more attention, it is important that the significance of non-economic factors not be overlooked. Questions of need, availability of manpower, quality of care, adequacy of physical facilities, and cost must be considered concurrently and projects evaluated in terms of all these characteristics.

In the final analysis, the problem of the cost of health care services is a matter of public choice. At any particular level of income, the community chooses between such options as expanded police protection, improved highways, and more health services. Given any particular income, an increase in the portion allocated to health services generally will lead to an increase in capital formation in the health sector. Thus, the rising price of health services may reflect choices by the public to consume more health services.

There is reason to believe that the public is not fully aware of the implications of choosing more health services over alternatives. When more health services are purchased less income is available for other purposes. Failure to recognize this economic principle fosters the false expectation that we can have more of everything with no change in prices.

It is on the basis of this false expectation that so much has come to be expected of health planning and, particularly, HSA's. Until the public media, providers, third party payers and health planning agencies begin to inform the public adequately on the nature of the problem of increasing health care costs, the public will continue to believe that health care can be made more accessible with improved quality within given cost structures. This is where an understanding of the need to exercise public choice is essential.

The decision to consume more health services is not simply a decision made by individual consumers. Total expenditures for health services are product of prices, which are largely administered through third party payment mechanisms, and utilization, "which is, in large measure, also administered; that is, determined by the physician".¹ Hence, the normal market constraints on increased prices and increased utilization are obscured by the unique nature of the market for health services.

From the perspective of the price of health services, capital expenditures in the health system are drawing increasing attention as a factor in the rising cost of health services. Although wages constitute approximately two-thirds of hospital operating costs, recent trends have concentrated the focus of concern on the growing proportion of health costs attributable to capital investments. In 1964, the cost for the average health facility expansion program was approxi-

¹ Rashi Fein, "Some Health Policy Issues: One Economist's View," Public Health Reports, LXL (September-October, 1975) 390.

mately \$26,000 per bed. By 1973 the cost per bed had doubled. It is estimated that, even with fiscal restraint and restrictions on expansion, expenditures throughout the U.S. for the construction of health facilities will be \$5 billion annually by 1980.² Substantial investments are required for health care facilities in order to comply with federal design and construction standards. The accelerated pace of medical technology has induced investment in the latest, most sophisticated equipment which may soon be out-of-date. Health care facilities constructed forty and fifty years ago anticipate large capital investments to replace the existing physical plant. All of these influence the need for capital investments.

Inasmuch as third party reimbursement is the major source of payment for inpatient services and third parties generally base reimbursement formulas on cost, the common effect of increased costs is increased revenues (within limits). If prices of health services are to be contained, given the unique nature of the market, then increases in costs must be contained. The area of health costs most subject to control is capital expenditures.

Even with control over costs of health services, total expenditures may continue to increase if utilization of health services increases. Again, the unique nature of the market keeps the demand for health services from being affected significantly by price. It is unlikely that consumers, who do not bear the actual burden of the costs of services which they receive, or physicians, who have major influence over the use of health services, will reduce utilization of health services in response to higher prices. In the absence of educational programs which encourage patients and physicians to refrain from unnecessary use of health services, expenditures therefore probably will continue to increase.

Until the utilization of health services can be changed the burden of containing health care costs will fall on restraining increases in price. That effort, in turn, will focus on holding capital expenditures in check. Restraint of capital expenditures depends on two judgments: need and economic consequences.

As mentioned above, the determination of need has been a major area of interest in health planning. The economic consequences of capital expenditures have not been as carefully considered as they might be. It has been common to pay careful attention to the internal financial feasibility of a capital expenditure by sponsoring institutions without considering the implications of the capital expenditure on other elements of the local health care system.

The sustained demand for capital funds in the health sector has led to the reconsideration of allocation of scarce capital funds in the economy as a whole, as well as, within the health sector. Furthermore, the decline in the availability of capital funds for the health system from philanthropic and public sources has forced sponsors of health care services into competition with other uses of capital funds. In the marketplace, health care facilities have had certain advantages stemming from third-party reimbursement policies. On the other hand, Medicare, Medicaid, and Blue Cross, as major purchasers of health services (approximately 60 percent of revenues), have limited the ability of health care facilities to change rate structures and, thus, to raise capital funds through operations.³ Finally, the effect on the balance sheet of acquiring large amounts of capital funds in the marketplace is compounded by long-term debt financing.

As capital costs are increased by growing dependence on debt financing, concern over the allocation of resources to the health system grows as well. In the past, demonstration by a health care facility of its ability to raise the required capital funds was considered by regional health planning organizations to be adequate evidence that a capital expenditure was justified, if all other non-financial criteria were met. The nature of third-party reimbursement, which does not contain incentives for hospitals to economize,⁴ has tended to support the demonstration of financial feasibility without regard to the optimal allocation of resources in the health system. Furthermore, in the health system the internal decisions of an organization such as a hospital can have significant implications

² W. Thomas Berriman, William J. Essick, Jr. and Peter Bentivegna. "Capital Projects for Health Care Facilities" (Germantown, Maryland: Aspen Systems Corporation, 1976), p. 3.

³ Lawrence Craven Pettit, Jr., *The Capital Expenditure Process in Hospitals* (unpublished dissertation), University of Virginia, Roanoke, Virginia, Pg. 1.8.

⁴ Ben Joseph Tuchi *Variables Influencing Hospital Costs in Seven Western Pennsylvania Hospitals* (unpublished dissertation), Saint Louis University, St. Louis, Missouri, 1970, pg. 206.

for neighboring institutions. These spillover costs and benefits make the health services market one in which individual organizations cannot act autonomously without jeopardizing the optimum functioning of the health system. Since there can be few strictly internal decisions, it becomes essential that the effects of internal decisions on the health care system be identified and that those internal decisions be evaluated in terms of their intended outcomes and their effects on the health system as a whole. Therefore, more attention is being accorded to the impact of capital investments on the health system and on the community, thus stimulating an examination of measures of his impact.

A factor of considerable influence on the size of capital expenditures is the physical design of a health care facility. While design is closely related to the functions of the facility and is affected by federal requirements, relatively small changes in design can have significant impact on construction costs. Therefore, to evaluate the impact of a capital expenditure adequately the regional health planning agency needs guidelines for physical design which will enable staff to consider whether the physical design of a facility results in a capital expenditure which may be excessive. Such guidelines or physical standards would serve as a tool for staff in evaluating the information provided on capital expenditure projects to determine if more information or additional justification for the project should be requested. Physical standards would not be used as the only criteria for making decisions on approval or disapproval of projects.

MEASURING THE IMPACT

Techniques for measuring the impact of capital investments and for determining the optimal allocation of resources in the health system are not new. Traditional approaches such as cost-benefit analysis and cost-effectiveness analysis have been applied widely in models for choosing among alternative public uses of funds. While their application to decisions regarding the health system is more recent, efforts have been directed toward refining these techniques.

Several problems are posed in applying cost-benefit and cost-effectiveness analysis to problem-solving in the health system. First, *all* the costs and benefits of a particular option must be measured. Since this must include spillover benefits and costs not directly attributable to the expenditure,⁵ problems of measurement arise. Second, there are difficult problems in units which can be measured.⁶ Third, all the costs and benefits must be converted into dollars. This raises questions, such as how one can "attach a dollar value to the benefit of improved health."⁷ Thus, the application of cost-benefit analysis and cost-effectiveness analysis presently has limited reliability.

In the absence of a reliable application of these traditional techniques, an alternative technique is needed by the regional health planning agency. Furthermore, until the agency can determine how extensive the capital funds market is for this region, there are questions which need to be resolved regarding the impact of one institution's investment on the plans of other agencies. If the capital funds market is substantially limited to this region, then investments in Greene and Fayette counties, for example, have an impact on investments in Pittsburgh and vice versa. Also, the degree to which the health facilities in this region compete for capital funds with other firms in this region must be determined. Since a regional plan could not identify priorities for the allocation of resources so specifically that every capital investment need in the system could be ranked according to its impact on the community, a technique is needed which can be applied to capital investments on a case-by-case basis. The objectives of such a technique would be: 1. to consider all capital investment projects with potential community impact; 2. to identify those projects which will have a possible unacceptable impact on the community; 3. to perform these functions as simply as possible.

The technique proposed to meet those objectives is a triggering mechanism which would be used by staff of the HSA in advising sponsors on the development

⁵ Roland J. Knobel and Beaufort B. Longest, Jr., "Problems Associated with the Cost-Benefit Analysis Technique in Voluntary Hospitals", *Hospital Administration*, XIX (Winter, 1974), pp. 43-44.

⁶ Rashi Fein, "Medical History and Medical Care" Oxford University Press: London, 1971, pp. 198-202.

⁷ George Walter Torrance, "A Generalized Cost-Effectiveness Model for the Evaluation of Health Programs," (unpublished dissertation), State University of New York, Buffalo, New York, 1971, p. 6.

of projects and in preliminary evaluation of projects in the review process. It would be used as an instrument strictly for determining whether a project might have potentially unacceptable community impact and would not be used as criteria for approving or disapproving a project. If a project is determined to have potentially unacceptable community impact, additional financial information or justification for the capital investment would be requested from the sponsor of the project. This evaluation would occur in a preliminary form at the staff level. Results of the evaluation would be provided to appropriate components of the agency involved in reviewing the capital investment project. The technique is limited in that it only addresses debt retirement. It is not a guarantee that the project is sound. However, the Committee recognizes that this is a beginning in the consideration of the impact of capital investments.

TRIGGERING MECHANISM

After a preliminary review of the internal consistency and completeness of financial information for a capital investment project, projects for which the total costs, as specified in the information requirements, are \$500,000⁸ or more would be subject to the triggering mechanism. Six financial indicators would be applied in this mechanism. If the standards for three or more indicators are not met, then the project would be identified as having possibly unacceptable community impact and additional information or justification would be required.

In applying this mechanism, the agency should be cognizant of the influence of changes in the interest rate on the financial indicators. With a significant decrease in the rate of interest, virtually all projects could meet the indicators. Therefore, the agency should monitor the prevailing interest rate closely. With a decrease in the interest rate, the agency may find it necessary to revise the norms set for each indicator. Furthermore, any capital investment project which uses an interest rate below the prevailing rate should be requested to explain the lower rate. The current prevailing rate is approximately 8 percent.

Another situation which requires special attention is a multi-facility project. Such projects can spread the effects of a capital investment project over a broader base of patient days or other units of service. Thus, in the case of multi-facility projects, attention should be directed especially to the manner in which costs are allocated among the facilities.

The financial indicators and standards to be used in the triggering mechanism are:

1. Per diem debt service as percent of inpatient per diem

The ratio of the per diem cost of debt service for inpatient services to the total per diem cost of inpatient services reflects the distribution between operating and non-operating costs associated with the delivery of inpatient services. As the ratio becomes larger, the distribution of costs between facilities' construction and delivery of health care services allocates a greater proportion of the health care dollar to construction. Maximum: 15 percent.

2. Total annual debt service as a percent of total annual operating expenses (including depreciation, interest, and amortized fees)

Similar to the indicator above, this ratio encompasses total debt service cost and total expenses. Maximum: 12 percent.

3. Dollar amount of per diem debt service

The per diem cost of debt service in dollars, as it related to inpatient services expresses the amount which the average inpatient pays per day for construction and financing. Maximum: \$30.

4. Debt service coverage ratio

The ratio of the revenue available for debt service after other expenses to the annual debt service requirement is a measure of the ability of a facility to generate revenues in excess of its debt service requirements. While interpretation of the ratio is open to some subjectivity, a general rule of thumb is that it should be greater than one and, at least 1.5. Minimum: 1.6.

⁸ This amount is small enough to include projects for health care facilities other than hospitals and large enough to include only projects which could be anticipated to have some community impact.

5. Ratio of debt to the capital cost of the project

This ratio measures the proportion of a project which is being funded through debt. Maximum: 80 percent.

6. Ratio of amortized cost of a capital expenditure to the capital cost of the project

The sum of debt service costs over the life of the debt or the total principal, interest and fees is the amortized cost. The ratio of this cost to the capital cost of the project reflects the total effect of debt financing on the cost of a capital expenditure project. Standard: 2.8.

STATEMENT OF RONALD E. ROSENBERG, VICE PRESIDENT OF PLANNING AND DEVELOPMENT, HOMEMAKERS HOME AND HEALTH CARE SERVICES

My name is Ronald E. Rosenberg, and I am Vice President of Planning and Development for Homemakers Home and Health Care Services, a subsidiary of The Upjohn Company, Kalamazoo, Michigan. Homemakers Upjohn is the largest single home health provider in the nation, with 217 offices across the country.

In 1976, Homemakers Upjohn employed approximately 50 thousand people, part time and full time, who delivered 14 million hours of service, the bulk of it in the areas of professional nursing, nurse aide, and home health aide care.

Due to the statutory restrictions of the Medicare Law, most of the company's services are provided to, and paid for by private patients.

In 1975, Medicaid spent approximately \$132 million on home health care, with New York alone accounting for almost \$107 million of the total. In that same year, Medicare spent just under \$200 million on Parts A and B—Home Health Care.

While these expenditures represent only a small fraction of the total Medicare and Medicaid Programs, they are increasing yearly, especially in Medicare, as the industry matures and proves its viability as a primary health care model for the chronically ill and disabled.

Homemakers Upjohn believes that if S. 1470 were to incorporate some administrative and reimbursement changes in the home health benefit, the long-range impact on the rest of the health care system would be to shift emphasis from expensive institution—where many of our nation's elderly and disabled are unnecessarily institutionalized—back to the home, a better setting and potentially a cost effective one.

We would like to discuss one of those administrative changes.

Because of the statutory restrictions of the Medicare law, most of Homemakers Upjohn's services are provided to, and paid for by private patients.

Section 1861(o) of the Social Security Act, passed in 1965 as part of the Medicare Law, defines a home health agency as "a public agency or private organization, or a subdivision of such an agency or organization":

1. which is primarily engaged in providing skilled nursing services and other therapeutic services;

2. which has policies established by a group of professionals, including one or more doctors and one or more nurses and which has its services supervised by an RN or a doctor;

3. which maintains clinical records;

4. which is licensed pursuant to State law, if the State licenses home health agencies, or is approved by the State as meeting the standards established for such licensing;

5. which has an overall operating plan and budget; and

6. which meets such other requirements as the Secretary may establish in the interest of health and safety.

The statute ends with the statement, "except that such term shall not include a private organization which is not a nonprofit organization . . . unless it is licensed pursuant to State Law and it meets such additional standards and requirements as may be prescribed in regulations . . ."

These, Mr. Chairman, are the conditions of participation for home health agency providers in the Medicare program, and, by practice, in the Medicaid program as well.

The intent of the law, as expressed in both the Senate Finance and House Ways & Means Committee Reports on the Social Security Amendments of 1965 was: ". . . that organizations providing organized home care on a profit basis

are presently nonexistent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards set by the legislation."

Homemakers Upjohn believes that Congress intended to allow tax-paying home health agencies to be Medicare providers. We believe that Congress expected each State to enact licensure laws for home health agencies, just as they have done for virtually every other segment of the health industry, not to mention beauticians and barbers, in the interests of the health and safety of their residents.

But to date, only 17 states have passed home health agency licensure laws. That's 17 States in 12 years.

Other than the conditions of participation which I have just listed, the only sanctioned standards for home health agencies are those established by individual state licensure laws.

Homemakers Upjohn is providing health care in 33 states that have no licensure laws. New York, which has such a law, has chosen to license only nonprofit agencies. Yet, even in New York where we are excluded from Medicare, Homemakers Upjohn is currently being reimbursed both directly and indirectly by state agencies and by nonprofit licensed Medicare agencies under 41 separate contracts or subcontracts! We are contract providers to such agencies because the nonprofit agencies lack the necessary resources to deliver needed service in the state. They can't handle the need for home health care.

Now, I ask you Mr. Chairman, does it make sense to you that we, as a proprietary agency, can deliver service under *some* government programs, but not serve Medicare? Remember we are actually serving nonprofit Medicare-certified agencies via subcontracts and in the other programs, where we are providing service, many of the recipients are also Medicare patients. This is a sad statement about the ineffectiveness of our programs to deliver care to people who need it.

Homemakers Upjohn proposes that the restrictive language in Section 1861(o) be deleted for two reasons: first, the law is discriminatory; second, there is a demonstrated need for our company's services.

Tax-paying home health agencies are the only class of profit-making providers discriminated against in the Medicare law. Profit-making nursing homes are providers; profit-making hospitals are providers; doctors are providers. Why have proprietary home health agencies been singled out for this discriminatory treatment?

One of the ironic twists of this profit/nonprofit situation is that the tax monies Homemakers Upjohn pays to the government are returned back to the company in the form of subcontracts with nonprofit agencies.

The growth and success of Homemakers Upjohn in the private market is a solid indicator of the need for and acceptance of our services. Since 1969, the company has grown from 29 offices to 217. In this time, the number of patients under our care has grown steadily. Obviously a lot of people think we're doing something right; they're paying for the service out of their own pockets.

This rate of growth is also related to an increasing need and demand for the home health care. The industry will continue to grow to meet this need.

America's medical care system has had tremendous success in wiping out or controlling infectious diseases. As a result, Americans are living longer. But the medical care system has not yet learned how to deal with the disabling effects of old age and chronic disease. As a result, the nation's over-65 population is growing steadily and is expected to reach 17 percent of the population in the next 50 years.

It is apparent to health experts in Congress, in H.E.W. and in industry that the nation has no comprehensive long term care benefit structure that will answer the needs of this increasingly large elderly population.

The Congressional Budget Office catalogued this need in a long term care report in February of this year. That report states that 300,000 to 500,000 adults can be accommodated by the current supply of home health agencies and day care facilities. On the other hand, the CBO states that 1.7 to 2.7 million adults have a current potential need for home health and day care. Conservatively, more than one million adults have an unmet need for home health care.

The CBO report also estimates that long term care spending by both government and private sectors will more than double by 1980. Currently, only 10 percent of all public funds are spent on home-based services, while, to quote the

report, "there is evidence that 20-40 percent of the nursing home population could be cared for at less intensive levels were adequate community based care available."

According to the same report, government-financed long-term care services were delivered in 1975 to 1.9-2.7 million people, although 5.5-9.9 million persons were functionally disabled. The CBO estimates that approximately one of eight disabled persons received no form of long-term care services.

If we believe these figures, it is apparent that the supply of home health agency services has to double right now to fill the current unmet need.

If Homemakers Upjohn alone were to become a Medicare provider today, we could just about double the availability of badly-needed home health services in the United States. Homemakers Upjohn does not need federal funding to start up or expand. We are ready right now. And with the projected need for growth in home care, we as citizens need every legitimate, ethical provider we can get.

For instance, in Georgia, Mr. Chairman, where there is no home health agency licensure law, Medicaid served 978 home health clients out of a total of 516,325 Medicaid clients in 1975, at a cost of \$254,724. Only 319 of these were elderly people. Medicare served a total elderly population numbering 428,895 and spent only \$1.8 million on home health care.

The unmet need is such that in Savannah, the Title XX people asked us to open an office. We have done so. In Atlanta, we have subcontracted with the VNA for home health aide services for almost two years. Our aides identified a need to supply shampoo, soap, and items such as Lysol to the patients at home. With VNA approval, we raised our hourly rate by 25 cents in order to supply these necessities which make the home environment more conducive to good health.

In Connecticut, the elderly population is 312,883. The 100 nonprofit agencies in that state employ 1,055 full time, and 1,239 part-time people, while the 12 proprietary agencies employ 1,099 full timers, and 909 part timers. Homemakers Upjohn offers 24-hour service, seven days a week—the nonprofits do not.

Because of this flexibility, Homemakers Upjohn has several contracts in the state. One of these is with Triage, a Section 222 demonstration project designed to prove the viability of an open-ended in-home service program. We are under contract to the project to supply registered nurses, home health aides, and homemakers. One of our patients in that program was a bedridden, obese 80-year-old woman at the time we started service. Our homemaker and her RN Field Supervisor immediately discovered that the woman was diabetic. After instituting the proper diet and making other necessary changes under medical supervision, this bedridden woman got out of bed and is currently doing very well for herself with minimal homemakers services.

In Connecticut, the ratio of home health aides to the elderly population is 1.1 per one thousand. By way of comparison, that ratio in Scotland is 8.4 per one thousand. In Scotland in 1970, 18,500 people were institutionalized out of a total population of almost 6 million. In Connecticut almost 22 thousand were institutionalized of a 3 million population.

In Missouri, another state where there is no home health agency licensure law, Homemakers Upjohn was subcontracting services to a nonprofit agency under a Title XX contract which covered a 14-county rural area in Springfield. The contracting agency dropped the contract. We have had to take it on because no one else would do it. We have utilized an out-reach program in hiring and have served that rural area without opening any new offices.

In Ohio, Mr. Chairman, the state elderly population is 1.4 million. Approximately 119 thousand people are confined to their homes, according to state estimates, with 67 thousand of them needing home health care. But in 1975, only about 25 thousand people received home health care under Medicare in Ohio, 3,550 under Medicaid.

The state of Ohio notes that one percent of the total population is housebound; two percent have limited mobility. Additionally, 5.2 percent of the non-institutionalized over-65 population in the state are homebound; 6.7 percent of them need help getting around. Ohio also estimates that 10-40 percent of its elderly citizens are unnecessarily institutionalized because of the lack of supportive services in the community. Sadly, these figures parallel those of the CBO report.

Although Ohio has no home health agency licensure law, Homemakers Upjohn is operating under three contracts now—two with state mental hospitals, and one with a Visiting Nurse Service (VNS).

We have been subcontracting with the Visiting Nurse Service of Summit County for a long time. Originally, this arrangement called for us to supply licensed practical nurses. The agreement was eventually expanded to include our home health aides. This service has been so successful, that the VNS has dropped its own home health aide program and now depends solely on Homemakers Upjohn. The reason for this is that Homemakers Upjohn designed and operates a home health aide training program with the Red Cross in Cleveland and Akron. An innovation in Ohio, this Red Cross/Homemakers Upjohn cooperative effort took so-called unemployable people, generally those on SSI or some form of welfare, trained them to be home health aides and put them back on the wage-earning rolls. VNS belief is this program has led to a mutually supportive and solid relationship.

Our manager in Cleveland, Patricia Cook, was asked by the National Council of Homemaker/Home Health Aides to participate in a training workshop with Case Western Reserve University on nutrition and housekeeping skills for homemaker-home health aides. The training workshop was approved by the state to meet National Council requirements. There were 250 homemaker-home health aide employees of nonprofit agencies undergoing the training. To our knowledge, this is the first time a proprietary has been asked for training input by a national association. Mrs. Cooke, by the way, was not paid an honorarium for her services.

Our Central Group Director is responsible for Homemakers Upjohn offices in four states: Ohio; Kentucky; North Carolina; Tennessee. Only Ohio lacks a home health agency licensure law. This creates some bizarre situations. For example, our Cincinnati Zone Manager serves private patients in Ohio, but he also runs a Medicare-certified agency in Northern Kentucky out of the same office, with the same staff and the same expertise.

I assure you, Mr. Chairman, that the story of cooperation and mutual dependence exhibited by Homemakers Upjohn and the government and the voluntary agencies of Ohio, Missouri, Connecticut, and Georgia are not isolated situations. The company is needed and depended upon in many states across the country. For example, we are working with the Red Cross to set up a home health aide training program on a national basis.

We believe it is time that the Congress recognize the maturity of the home health industry and the acute need for providing access to its care. We believe that Homemakers Upjohn has proven its ability to provide quality care. We have proven the need for the company's services, in both the private and public sectors.

If it is time to make home health care more accessible to those in need, then it is time to end Medicare and Medicaid's discrimination against tax-paying home health providers.

Homemakers Upjohn urges the Congress to delete from Section 1861(o)(6) the phrase "except that such term shall not include a private organization which is not a nonprofit organization exempt from federal income taxation under Section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to state law and it meets such additional standards and requirements as may be prescribed in regulations . . .".

All providers should be equal under the law and answerable to a single set of standards. Let's mobilize forces to provide care. If a particular agency can't cut it, take away its certification. Above all, let's certify home health providers on their ability to do the job, not their tax structure. To do otherwise is to deny care to people in need.

S. 1470 ought to be the vehicle to fill this need.

STATEMENT OF HOSPITAL ASSOCIATION OF NEW YORK STATE

This testimony is submitted by the Hospital Association of New York State on behalf of its members, 300 voluntary and public nonprofit hospitals and health care institutions. These institutions represent about 90% of the general, acute care hospital admissions in New York State, and approximately 10% of those for the entire United States.

As we will cite below, there are a number of reasons for the increasing costs of health care. While it is important to understand these reasons, the fact remains that regardless of why health care costs are increasing, they are increasing too rapidly and something must be done to slow that increase. There are two major pieces of legislation now before Congress oriented toward that goal, the "Hospital Cost Containment Act of 1977" and the "Medicare-Medicaid Administrative and Reimbursement Reform Act," S. 1470 (Talmadge).

We are concerned particularly about the shortcomings of the Administration's bill. It is a stop-gap cost control program with no incentives for hospitals. Further, it subjects them to controls not faced by any other segment of any other industry, it has no termination date, and it has no designated replacement. We believe the Administration's proposal can only result in reimbursement inequities to hospitals, and we vigorously oppose its enactment.

On the other hand, the bill introduced by *Senator Talmadge* and 10 sponsors addresses not only hospital reimbursement but practitioner reimbursement, long-term care, and the administration of the Medicare and Medicaid programs. Its approach is rational and based on an understanding that there are long range problems in the health care field which can only be dealt with by a long range plan which considers the system in its entirety. As with any major piece of legislation in the health care field, there are provisions which we would prefer to see altered and we will address those provisions in this testimony. We recognize the time and effort expended in preparing this fine piece of legislation, we applaud you for it, and, given certain changes which we will recommend farther on in this document, we support passage of the "Medicare-Medicaid Administrative and Reimbursement Reform Act," S. 1470.

REASONS FOR INCREASE IN HOSPITAL COSTS

There are many reasons for the increasing cost of hospital care. Some of the major ones are summarized below.

1. *Medical advances and the cost of technology.*—The capability of hospitals to provide care has improved rapidly over the last ten years with the spread of vital services such as those provided in the intensive care unit, coronary care unit, inhalation therapy service, and postoperative recovery unit. Hospital personnel to staff these services have created new positions requiring special training such as respiratory therapist, surgical technician, and nuclear medicine technologist. These units and the labor forces to staff them are expensive.

2. *Labor.*—Hospitals are roughly twice as labor intensive as most industries. Since the average payroll and fringes in the New York City area are about 70 percent of operating expenses, a 12 percent increase in wages would add 7.4 percent to the cost of running a New York City hospital as compared to only 3.6 percent of the cost of running an average industrial plant.

3. *Market basket.*—Hospitals use different goods and services from those of other industries. Prices for health related goods and services are increasing at a higher rate. For example, the malpractice insurance rate for some hospitals has increased by 1500 percent during the past year and 300 percent increases are the norm rather than the exception. Hospital costs for general liability insurance, natural gas, No. 6 fuel oil, and building construction and renovation have skyrocketed in recent years.

4. *Hospital-physician relationship.*—Since hospitals do not decide when or whether to admit patients and provide service, the role of the physician must be considered in evaluating increasing hospital costs. Factors such as the increase of defensive medicine and physician pressure to continually upgrade facilities and equipment which results in technological obsolescence add to increasing hospital costs.

5. *Aging population.*—The percentage of U.S. citizens now 65 has almost doubled since 1930 and is expected to continue increasing. The aged require care more frequently and more intensive attention in the hospital; thus causing increased hospital costs.

6. *Third party payers.*—Less than 10 percent of inpatient hospital payments are made by the patient himself, leaving over 90 percent to be paid by third parties. There is little incentive for the public to put consumer pressure on hospitals and physicians under these circumstances.

7. *Government regulation.*—Last fall, the Hospital Association of New York State's Task Force on Regulation reported that there are at least 164 federal,

state, local and other agencies involved in the regulation of New York State hospitals.

Following are our section-by-section comments on S. 1470, divided into the four main topical areas addressed by this legislation: hospital reimbursement reform, practitioner reimbursement reform, long-term care reforms, and administrative reforms.

HOSPITAL REIMBURSEMENT REFORM

Criteria for determining reasonable cost of hospital services (sec. 2)

Section 2 of S. 1470 requires HEW to establish "an accounting and uniform functional cost reporting system . . . for determining operating and capital costs of hospitals providing services" not later than April 1, 1978. In New York State we have been operating under a uniform reporting system since 1970. From our experience, we urge that care be taken in development of a cost reporting system to ensure uniform procedures for allocation of costs so that reasonable costs can be consistently determined. It should be specifically stated in the legislation that the purpose of developing a uniform functional cost reporting system is to produce *comparable data*. Further, an evaluation of the new system's effectiveness should be made and reported to Congress annually. Not only is comparability essential for government determination of reasonable cost when submitting a rate appeal, but also hospitals need comparable data to evaluate their performance with that of other hospitals. Again, we urge that comparability be stressed in development of this uniform functional cost reporting system. For maximum benefit, these data should be made available to hospitals on a routine basis to encourage comparisons which could be expected to result in voluntary efforts to contain costs.

In developing the system of hospital classification, this legislation allows each accredited medical school to have only one primary hospital affiliate. We find this limitation restrictive and recommend classification of hospitals affiliated with medical schools be left to the discretion of HEW, so that varying circumstances and situations can be taken into account and the classification system can obtain much needed flexibility. This legislation requires a system of hospital classification for purposes of comparing costs of similar hospitals. If applied reasonably and fairly and if reasonable exemption criteria are developed, we believe this grouping procedure can be workable on the national level. We also believe this classification process should lead to the development of screens for the purpose of determining what activities of a particular hospital might be reviewed for possible excess costs. But, screens should not be used for arbitrary denials of costs.

Although there are many factors which must be considered in developing groupings in addition to those proposed in your legislation, we believe that your delegating this authority to HEW is a proper method of handling the problem. In developing the final classification system, HEW will have to consider a wide variety of reasons for diversity among hospitals including the hospital's mission, scope and complexity of services, location, medical staff composition, diagnostic case mix, age of patients, and economic conditions in the hospital's locality. In fact, as hospital grouping methods become more sophisticated, subtle factors such as the different age and physical characteristics of the hospital's physical plant will become important in truly ascertaining the reasonable costs of a hospital providing services.

In this year's version of the bill, the definition of routine operating costs has been changed to exclude malpractice insurance expense. Since the insurers of many of our hospitals set malpractice premiums by combining risk exposure under policies for general liability, we believe that these expenses also should be recognized as being inextricably combined in the actuarial processes and both excluded from routine operating cost calculations.

Other costs which should be excluded from the definition of routine operating costs are those associated with special nursing units such as intensive care, coronary care, and burn units. Costs of these units are high and their development in hospitals varies widely. Under the concept of regionalization, all hospitals do not need such specialized services as burn units. There might well only be one to serve for a number of hospitals and that one hospital should not be penalized for providing this much needed specialty care.

In addition, we urge that you exclude *all energy costs* from your definition of routine operating costs. There is presently no methodology for hospitals to

segregate the cost of heating and cooling from other energy costs as this bill would require. To do so would mean not only accounting changes, but also incorporation of expensive new metering systems within hospitals.

A system of prospective reimbursement based upon historical costs and hospital groupings, such as proposed in this legislation and such as has been in existence in New York State since 1970, tends to inhibit and discourage development of innovations and improvements in the delivery of health care. The basic premise of this system is to perpetuate the old ways of doing things by only allowing the costs of doing things the old way. Reimbursement is set by taking past costs and adding an amount to adjust for inflation in the prices hospitals have to pay for goods and services. This process does not pay for the cumulative impact of the costs of a myriad of technological improvements which occur between the base year and the current year. We recommend that allowances be made to pay for such technological advances when setting reimbursement levels.

The prospective reimbursement system must recognize losses incurred by voluntary hospital providers because of ambulatory care provided to the medically indigent not covered by third party insurance. Their inability to pay for the costs resulting from care provided to these patients results in bad debt losses to the hospital. We recommend that the amount of these losses be recognized as a cost of serving the community which should be added to the cost of inpatient care in determining Medicare and Medicaid payments. Appropriate providers should be required to meet regulatory and planning agency criteria establishing such community service costs as an integral component of the health care system payment program.

The adjustment of the personnel component of the per diem payment rate for routine operating costs will be based on a wage index reflecting the general wage levels in the areas in which the hospitals are located. We recommend that this wage index be devised to directly reflect the labor market from which hospital employees are drawn rather than the general labor market.

Further, S. 1470 allows for a special one-year adjustment for areas where hospital wages are significantly higher than the general wage level. If this provision is intended to drive down the costs of labor in hospitals in those areas, we feel it is doomed to failure. In New York City for example, hospitals have been faced with considerable union activity in recent years and have faced severe periods of crisis when union employees have gone on strike. Wage contracts have been the subject of long and difficult negotiations caused by the union's desire for ever-increasing wages and the hospital's inability to pay those increases. We therefore believe that the waiver provision in this bill is a necessity, but strongly recommend you extend it from one to three years. This would give hospitals in areas where hospital wages are significantly higher than the general wage level sufficient time to come more in line with the general wage structure.

In this legislation, the term "adjusted per diem payment rate for routine operating costs" reflects an adjustment in routine operating costs due to increases in prices facing hospitals. This adjustment will take place at the end of the year and will reflect the lesser of: (1) the actual cost increase experienced by the hospital, or (2) the actual increase in costs which occurred in the mix of goods and services in the area. This penalizes a hospital which is able to keep its cost increases at a level below the costs of other goods and services in the area. Rather than implement this section, we recommend that hospitals be reimbursed for the price levels of goods and services. This will provide an incentive for hospitals to cut costs rather than encourage them to push costs up to the general level of prices of goods and services in the area.

Hospitals may file for an exception under this legislation if they: (1) are in an underserved area, are certified as being necessary by the planning agency, and are underutilized, or (2) in the aggregate have patients requiring a substantially greater intensity of care than other hospitals in the same category. It has been our experience in New York State while operating under a program substantially the same as that proposed in S. 1470, that it is essential for hospitals to have effective access to an administrative relief mechanism to apply for rate revisions. For hospitals certified to be necessary by the local planning agency we recommend the establishment of an administrative rate appeal structure specifically tailored to assure the hospital's financial viability. It must be recognized that the application of a grouping mechanism such as presented in

this bill will at times result in inequitable reimbursement to hospitals doing an efficient and effective job of providing health care services. It is important in the administration of this program that such a hospital have the opportunity to obtain administrative relief from an objective and independent agency such as an appeals review board.

This legislation provides for an adjusted per diem payment rate to reflect the higher prices prevailing in Alaska or Hawaii. Given the recognition that higher prevailing prices directly reflect on the cost of providing health care, we question why only two locations were selected as areas with higher prices. It is well known for example, that the prices of goods and services in New York City approach and even surpass in some areas the prevailing prices in Alaska and Hawaii. We recommend that the discretionary authority given to the Secretary in this provision be extended to allow him the opportunity to increase the adjusted per diem payment rate in areas of the United States in addition to Alaska or Hawaii which have higher prevailing prices than in the rest of the country.

Section 2 specifies that hospitals shall not increase amounts due from any payer in an effort to offset title XIX reductions. We support that mandate. However, we would also like to point out that hospitals have traditionally had a single charge structure for services rendered to any and all patients, regardless of the reimbursement methodology those patients use. These charges are based upon the services rendered in all but a few instances where the hospital has a flat rate which applies to all patients. Medicare and Medicaid have special reimbursement rates and, especially under Medicaid, reimbursement levels frequently do not cover the costs of providing services. This leaves the hospital in an untenable position when it comes to providing care for individuals such as those covered by automobile insurance who often are suffering from severe trauma when admitted. The cost of providing care to seriously injured patients such as these is higher than for the average Medicaid patient. Therefore, it is essential to understand that hospital charges are not related to prospectively computed all-inclusive per diem government payment rates, nor should they be.

The effective date for the reimbursement provisions of this legislation was originally October 1, 1980. As addressed earlier in this testimony, the problem of the increasing costs of health care is pressing and urgent. Therefore, we concur that the effective date be advanced one year to October 1, 1979. We understand that there are systems which must be put in place and adjustments which must be made, but we feel it essential that these changes be made swiftly and that an improved and more reasonable national Medicare and Medicaid reimbursement system be put into effect as soon as possible.

Section 2 allows for a state to operate their own reimbursement program for Medicare and Medicaid if they have a contract with HEW to operate an experimental reimbursement system and if they meet certain requirements. We believe that minimum federal guidelines should be developed which would stipulate: (1) which costs are allowable; (2) recognition of full financial requirements for hospitals; (3) establishment of a fair and equitable appeals procedure to ensure due process; (4) requirement that the state regulatory body be an independent agency and that rates not be predicated on the state's ability to pay as in New York State, but on a mechanism to assure the financial viability of hospitals which are providing services in a responsible manner; and (5) required evaluation by HSA's of reimbursement system's impact on the health delivery system.

Payments to promote closing and conversion of underutilized facilities (sec. 3)

The 1977 Talmadge bill permits approval of an application for a transitional allowance prior to implementation of the conversion. We think this change is essential to the success of Section 3 of the bill and commend you for including it in the new legislation. The number of hospitals which may receive a transitional allowance prior to January 1, 1981 is limited to 50. We recommend that the Secretary of HEW be authorized to review the effectiveness of the transitional allowance program between now and 1981 and expand the program beyond 50 hospitals if he deems it advantageous.

Federal participation in hospital capital expenditures (Sec. 4)

A major change in this section from last year's bill is a requirement for section 1122 Planning Agencies to be the State Health Planning and Development Agency. We believe that this recommendation is reasonable and is supportive of P.L. 93-641 and the entire health planning process.

This section requires that proposed capital expenditures in a standard metropolitan statistical area located in two states be given approval by both states' planning agencies. We find this provision particularly troublesome. The New York, N.Y.—New Jersey SMSA, according to the U.S. Bureau of Census 1974 population figures, had a population of 9,634,400. Of that population, 874,600 people resided in Bergen County, New Jersey thus making a two-state SMSA. Under the above provision, any proposed capital expenditure in either New York City or Bergen County would have to be reviewed by both states' planning agencies, obviously an unreasonable requirement. Therefore, we recommend that in a two-state SMSA with 90% or more of the population residing in one state, capital expenditures in either state be reviewed only by that state's planning agency. In addition, we recommend that the comments of the other state's planning agency be considered in this review process.

PRACTITIONER REIMBURSEMENT REFORM

Hospital associated physicians (sec. 12)

This section limits the charges for a physician's services to the amount equal to the salary which would reasonably have been paid if the physician were in an employment relationship. To the extent this provision will do away with excessive payments to hospital associated physicians we support it. However, we are concerned that it directly affects the ability of hospitals to enter into reasonable contracts with physicians. Therefore, although we support the intent of this section of the legislation, we also recommend that information be collected on actual amounts now being paid to hospital associated physicians, what those amounts are being paid for, and any other information which would help develop more appropriate and equitable methods of reimbursing hospital associated physicians. It is also important that, when collected, this information be shared with hospitals to assist in developing better employment relationships.

LONG-TERM CARE REFORMS

Hospital providers of long-term care services (sec. 20)

Rural hospitals would gain valuable flexibility under this provision. Under certain conditions, they would be able to utilize inpatient facilities to furnish services which would normally be considered post-hospital extended care services. The Hospital Association of New York State supports this provision.

Reimbursement rates under medicare for skilled nursing and intermediate care facilities (sec. 21)

This provision allows for the state to include a reasonable profit for an ICF or a SNF. It is our recommendation that the language in this provision be changed after the word "inserting", to "(and which should include a reasonable operating margin for the facility in the form of: (a) fixed per diem amounts, or (b) incentive payments related to efficient performance, or (c) a rate of return on net equity)."

Medicaid certification and approval of skilled nursing and intermediate care facilities (sec. 22)

This section would extend to HEW final authority to approve or disapprove certification by a state of a SNF or an ICF for participation in Medicaid. It also extends to a facility which is dissatisfied with the Medicaid certification decision by the Secretary the right to a hearing in the same manner as is now available to Medicare. We strongly support this change because it is an effort to provide for a timely due process hearing and greatly improves the fairness of the certification procedure.

ADMINISTRATION REFORMS

Establishment of health care financing administration (sec. 30)

This section will mandate by law an administrative change recently made by the Department of Health, Education, and Welfare. We agree that the HCFA should improve HEW's administration of health care programs and stress our position that this change must be accompanied by the consolidation of overlapping positions and by the improving of lines of authority and communication between HEW and hospitals.

State medicaid administration (sec. 31)

This provision is an effort to improve the Medicaid Administration by the states. We support this and all measures to improve Medicaid administration. Specifically we favor positive incentive measures such as that which rewards states for exceeding two or more requirements of Medicaid administration by making them eligible for federal matching of 75% of certain administrative expenses.

Procedures for determining reasonable costs and reasonable charges (sec. 40)

We believe this legislation has been improved by the deletion of provisions requiring HEW's review and approval of all contracts over \$10,000.

SUMMARY OF RECOMMENDATIONS

1. In development of a uniform functional cost reporting system, the primary consideration must be that comparable data be the objective.
2. Classification of hospitals should lead to the development of screens which should be used by regulatory agencies to evaluate allowable costs.
3. Classification of hospitals affiliated with medical schools should be done on a case by case basis by HEW.
4. General and professional liability, the cost of operating special nursing units, and all energy costs should be excluded from the definition of routine operating costs.
5. Outpatient deficits because of ambulatory care provided to the medically indigent should be added to the costs of inpatient care in determining Medicare and Medicaid payments.
6. The wage index component of the per diem payment rate should reflect the labor market from which hospital employees are drawn.
7. The adjustment for hospitals in areas where hospital wages are significantly higher than the general wage level should be extended from one year to three years.
8. Hospitals should be reimbursed for the price levels of goods and services in their area, not for the lower of their actual costs or the costs of goods and services in their area. This will give hospitals an incentive to cut costs rather than increase them to the general level of prices of goods and services in the area.
9. An appeals mechanism allowing for due process must be developed to assure equitable reimbursement to hospitals with unusual circumstances which are doing an efficient and effective job of providing health care services.
10. The Secretary should be given discretionary authority to extend increases in the adjusted per diem payment rates to areas with high prevailing prices other than Alaska or Hawaii.
11. States should be given an exemption from this bill's reimbursement methodology only if they meet certain federal guidelines requiring them to establish a fair and impartial reimbursement mechanism which would assure the economic viability of hospitals providing service in a responsible manner.
12. To address the problem of rapidly increasing health costs, we recommend the effective date of this legislation be moved up one year to October 1, 1979.
13. The Secretary should be authorized to review the effectiveness of the transitional allowance and expand the program beyond 50 hospitals if he deems it advantageous.
14. In a two-state SMSA with 90% or more of the population residing in one state, capital expenditure review should be conducted by only the applicable state planning agency.
15. Information be gathered on reimbursement to hospital associated physicians and more appropriate and equitable reimbursement methods be developed for their reimbursement and be shared with providers.
16. It should be mandated that ICF's and SNF's be allowed to have a reasonable operating margin.

SUMMARY

In summary, the change we have recommended above should not detract from your effort to slow the increasing cost of health care. The "Medicare-Medicaid Administrative and Reimbursement Reform Act" applies a well-conceived long-term approach to this problem, an approach which will operate in the short-term to control increases in hospital expenditures without substantially dis-

rupting the health-care delivery system. We find this a more reasonable approach to controlling the increase in health care costs than the Administration's proposal, and support the passage of S. 1470, incorporating the above recommendations.

STATEMENT OF THE HOSPITAL FINANCIAL MANAGEMENT ASSOCIATION

The Hospital Financial Management Association is a professional membership organization representing more than 15,000 individuals who hold financial management positions in hospitals and allied health care institutions or who are directly involved in organizations related to health care financial management. These are the individuals who will be responsible for implementing the accounting and reporting provisions of this legislation, if enacted.

We urge that the amendment of Section 1861(aa) (1) (A) of the Social Security Act made by Section 2 of S. 1470, be modified to delete reference to "accounting." While we have concern even about provisions for "a uniform functional cost reporting system" we understand the government's desire for information on which to base realistic evaluations of financial information. The word "accounting" in this section is not necessary to this objective, however. Past experience shows that vague provisions concerning "accounting" may not be implemented in conformity with intentions or expectations.

HFMA's Principles and Practices Board has issued a Statement on Uniform Accounting and Reporting. The Principles and Practices Board statement was not prepared with specific reference to this or any other specific legislative effort but the conclusions are pertinent. Our thoughts on Section 2 are related to the Principles and Practices Board conclusions.

1. The primary purpose of hospital accounting is to meet the needs of hospital management.

The difference between "management" information and "functional" information is central to HFMA's concern. A competently designed chart of accounts will provide both "management" and "functional" information and meet the uniform functional cost reporting objectives of Section 2. The financial and statistical information system of the hospital need not be designed on a functional basis, however.

2. A system of accounting can be, and has been, developed which meets the requirements of hospitals.

We feel that "generally accepted accounting principles" as augmented and interpreted by the American Hospital Association's Chart of Accounts and the American Institute of Certified Public Accountants' Hospital Audit Guide are an adequate guide to achievable uniformity.

3. Mandating a uniform chart of accounts for all hospitals will make it necessary for individual hospitals to maintain duplicate accounting systems.

The Principles and Practices Board cautioned about a mandated uniform chart of accounts. A "uniform functional chart of accounts" does not provide information useful for internal management and we must avoid any interpretation that Section 2 authorizes such an effort.

4. Uniform reporting by hospitals can be achieved with adequate definition of reporting requirements but does not require a mandated uniform chart of accounts.

Definitions and clear understanding of intent is important. Attention is called to the definitions contained in the Principles and Practices Board Statement.

5. Existence of significant differences among hospitals severely limits the validity of comparisons of reported results.

We appreciate the need for accurate and comparable data to facilitate health policy decision making but caution that there not be unrealistic expectations of comparability.

6. Substantial additional costs would be incurred to install uniform accounting in hospitals with no demonstrated evidence of the cost effectiveness of such.

HEW's Office of Research and Statistics has estimated the cost of their present effort to develop a uniform chart of accounts at \$70 million with no measurable savings. Any effort at uniformity must give special consideration to small hospitals.

A copy of HFMA's June 1977 Journal is attached.¹ In addition to the Principles and Practices Board Statement No. 1, it contains other interesting material relating to uniform accounting and reporting.

¹ The Journal will be made a part of the official committee file.

STATEMENT OF CHARLES T. WOOD, DIRECTOR, MASSACHUSETTS EYE AND EAR INFIRMARY, BOSTON, MASS.

To: The Subcommittee on Health of the Senate Committee on Finance.

The Massachusetts Eye and Ear Infirmary is a specialty teaching hospital of the Harvard Medical School group, with approximately 11,000 inpatient admissions, 81,000 outpatient visits, and 35,000 emergency visits per year.

At the Massachusetts Eye and Ear Infirmary, we have followed closely the development of S1470, the Medicare/Medicaid Administrative and Reimbursement Reform Act of 1977, as well as S1391, the legislation proposed by the Carter Administration. While we view S1470 to be much less restrictive than S1391 in terms of the public's access to appropriate medical care, we believe that S1470 in its attempt to identify "hospital reasonable cost" will do considerable harm to the public. The grouping mechanism outlined in S1470 will perpetuate the inability of providers, consumers, and payors to identify true cost, regardless of whether the setting for care delivery is a teaching institution, a high level acute care community hospital, or a hospital with sub-acute patients. S1470 in our mind will encourage all institutions to give the lowest level of care possible because of income restrictions imposed by "grouping".

This hospital has researched for some years the methodology of measuring workload by diagnosis by day, and we have concluded that regardless of what Bill is eventually passed, or what reimbursement mode eventually adopted, or even what further controls are imposed upon hospitals, the inability properly to account for the true cost of health care delivery will result, as it has in the past, in the following: further confusion, further restrictions imposed on the efficient provider, fewer penalties impacting the inefficient provider, and the general downgrading of health care delivery in this country . . . all as a result of our continuation, nationally, to utilize improper accounting systems.

We have evidence that certain "payor" groups are in reality paying more than the true cost for their constituents or subscribers, at least at the Infirmary, while other payor groups are paying less than the true cost. Our studies also have shown us that hospitals will vary somewhat in terms of cost, regardless of the classifications suggested in S1470. This variance is primarily the result of the distribution of certain types of patients in one hospital as opposed to another hospital.

Mr. Chairman, we believe that hospitals can and should be compared with each other for the purpose of monitoring efficiency, but we are equally convinced that such comparisons are impossible to monitor on the basis of the proposals in S1470 relative to grouping hospitals. Indeed, teaching hospitals within university settings are different due to a difference in case mix; this difference in case mix has a significant effect on their cost of care delivery.

In addition to this letter, we offer to be published as part of the Testimony for the Record relevant to S1470 the attached monograph, which describes our program of cost accounting at the Massachusetts Eye and Ear Infirmary. We believe this program to be at the very least a theoretical concept of the direction in which health care cost accounting has to move before any Bill designed to maximize the efficiency of the health care delivery system can be effected. Along with this submission, we would also like to invite you, your staff, the membership of the Subcommittee on Health and/or the Senate Finance Committee, to communicate directly with us if further information and even a presentation of the theories and methodology which we describe is desirable. As you will see by reviewing the monograph, we are advocating not only uniform cost accounting (a point to which S1470 admirably addresses itself), but also a cost accounting system that addresses itself to the identification of the true costs of delivering medical care.

May I add in summation, Mr. Chairman, what may seem like a bold statement: we believe that the present cost accounting system as used by the health care industry and perpetuated by administrative regulations in the private sector and by legislation in the public sector, has led us into a chaotic situation, one that needs to be addressed at the outset, irrespective of what control legislation is ultimately passed by the Federal Government.

Thank you very much for your indulgence, and we look forward to further communication with the Committee.

SPLIT-COST ACCOUNTING BY CHARLES T. WOOD, MASSACHUSETTS EYE AND EAR
INFIRMARY

For years, many of us in hospital administration have been uneasily aware of the fact that modern health-care delivery has raced far ahead of our ability to account and charge for the services rendered by our institutions.

Historically, it was relatively simple. With comparatively little specialization, uncomplicated technology, and essentially similar levels of care offered throughout most institutions, the matter of accounts and charges seemed fairly straightforward. We averaged all of our charges out by the numbers of patients per day and came up with a per-diem rate that has been the characteristic of hospital charges since the 1800's.

But things have changed, and changed so dramatically that we find a highly technological, frequently specialized late-twentieth-century industry doing its accounts with a quill pen. With all of our computers, automated laboratories, and incredibly complex health-care-delivery systems, and with all of the demands and needs of a restless, mobile, and sophisticated society, we handle our charge accounting in a way that wouldn't have surprised Charles Dickens. It's as if Mr. Micawber were processing all purchase orders for the NASA Space Shuttle program.

Today's cost accounting methods give no clue as to the kind and intensity of care delivered to individual patients. Reimbursement schedules are no more enlightening. All costs and, in effect, kinds of care are ground through an averaging machine that comes up with a total figure, uniform for all patients in a given institution.

So hospitals are known to charge X dollars per day for routine daily services. Period. Tonsillectomy? Radical mastectomy? Appendectomy? Total hip replacement? No matter. You (or your insurer) pay the X dollars per day. Nobody knows what the payments are for, except that one presumes they represent what it costs for the institution to offer its care. If the institutions receive less than the figure they ask they have to cut services, personnel, or go out of business. It's no wonder that the public image of health care institutions so often inspires hostility. The averaged-out, inexplicable charges seem as one with monolithic institutions whose nature and motivations are at best unclear and at worst ominous.

But the public image, as serious as it is, is not as critical as the fact that we ourselves are often unclear as to what we're charging for. Current methods of cost accounting and reimbursement often obscure the true cost of services provided. Because the averaging-out system offers no ongoing measure of productivity and efficiency within an institution, it makes practically impossible any meaningful comparisons between institutions. To a large extent, we operate in a vacuum, and the wide spectrum of hospital cost legislation at the state and federal levels indicates that things just can't keep going on the same old way.

At the Massachusetts Eye and Ear Infirmary, we have been working for some years to come up with a hospital accounting system that would allow us to measure the actual cost of the care we were delivering. We wanted a system that would function as a means to several highly desirable ends: a system of charging patients for the care actually delivered, which eliminated the inequities inherent in a system that spread all charges out among all patients; a system that would help us to project our needs for equipment, services, and personnel accurately enough and far enough in advance to improve the efficiency of our operation; and, if it was successful, a model which other institutions might follow and which might lead to a more reasonable and useful basis of comparison.

Some ten years ago, the Infirmary began gathering data on the various types of procedures performed at our hospital and the physicians who performed them. With this data we were able to implement a unique bed scheduling system based upon predetermined lengths of stay by diagnosis or procedure. Encouraged by the success of the bed prescheduling system, we expanded our data base and began to preschedule operating room time by procedure. Today, booking of the patient's bed and operating room time is done simultaneously by the patient's admitting physician, and usually only one telephone call is required to the Infirmary's central scheduling office to complete all the necessary arrangements.

The experience we gained in predicting lengths of stay by diagnosis or surgical procedure was in fact the cornerstone of our efforts in the early 1970's to discover a way of predicting how much nursing care our patients would require,

depending on diagnosis and procedure as well as day of illness. Using the PETO system* for measuring the amount of effort required to complete direct patient care tasks on our nursing stations, we gradually began to build a picture, or curve, of each diagnosis or procedure in terms of the amount of clinical care the average patient with that diagnosis or procedure would require on each day of his/her hospitalization. The establishment of this series of clinical care curves was in fact the most complicated part of what is truly a very simple split cost accounting system for inpatient billing that is now in operation at the Infirmary. The split cost accounting system is in fact the basis of our hospital's current Pilot Program with Blue Cross of Massachusetts, a program which is now in its second year.

The Massachusetts Eye and Ear Infirmary's split cost accounting system included three discrete cost categories that relate directly to the three essential elements of a hospital stay; namely, cost per patient, cost per patient per day, and cost of clinical care. This identification of the factors inherent in the existing day rates may finally resolve the old question of why hospital day rates have varied so markedly from one institution to another over the years. Under split cost accounting the true elements of hospitalization are identified, making the cost of providing a hospital room much more easily comparable everywhere because the same elements are assessed.

(1) Cost Per Patient (Hospitalization Cost): The measurable 'cost' of being a hospital patient. It is each patient's share of the costs entailed in being scheduled for admission, the admission process, the keeping of a set of medical records, the billing procedures and cashier operations. It also includes a per patient apportionment of plant and administrative overhead. (2) Cost per (Patient) Day, including the usual daily costs for room, meals, dietary needs, laundry routine, pharmaceuticals, medical and surgical supplies, and incidentals. Finally, (3) Cost of Clinical Care, the cost of direct care in accordance with diagnosis, surgical procedure, and the patient's point-in-progress toward recovery. Before going further into descriptions of each of these three components, it should be noted that ancillary services are billed on the traditional charge per test or unit of service basis.

The hospitalization charge is a one-time charge regardless of length of stay. Compared with the "per diem" system it has greater impact on the short-stay patient but it is more equitable in the overall sense that under the "per diem" system the long-stay patient pays a proportionately larger share of these costs and is in fact subsidizing the hospitalization for the short-stay patient. Once the hospitalization cost has been isolated the true per-day cost emerges.

The last component of the new system is the clinical care unit. A clinical care unit is essentially a relative value unit given to a direct care service or treatment provided to a patient. To this relative value unit we assign a monetary value for purposes of in-patient billing. As mentioned earlier, we at the infirmary have worked at defining the number clinical care units required by our patients based on diagnosis and surgical procedure using the PETO system. In this system, one clinical care unit equals approximately seven and one-half minutes of nursing staff time, bearing in mind that the clinical care unit is only used to measure direct patient care activities such as toilet, treatments, vital signs monitoring, respiratory aid, etc.

From the data base we have developed on clinical care units, we can predict by diagnosis and surgical procedure how many clinical care units a given patient is likely to require on each hospital day from his/her day of admission to the day of discharge. We know, for example, that a child with strabismus (squint) will require 15 clinical care units on the day he or she is admitted. The far more seriously ill laryngectomy patient, however, who is largely able to care for himself or herself preoperatively, will require only 5 clinical care units on day of admission. We have been able to develop a workload curve, as we said, by diagnosis and surgical procedure on a day-to-day basis that can be used to predict the clinical care requirements of patients' in-house and those to be admitted. The implications of the clinical care unit system for nursing department staffing and budgeting are considerable, but are beyond the scope of this article.

Of course, each service provided as part of general clinical care is not a direct patient care service. We know that a portion of the time every member of a nursing shift is spent in activities other than direct care, such as conferences with

*Poland, M., et al., PETO—a system for assessing and meeting patient care needs. *Amer. J. Nursing* 70:1479, July 1970.

other members of the medical team, consoling the patient, etc. Every hospital can determine for itself how much time its nurses spend in indirect care activities. A ratio, for example, could be developed on an eight-hour nursing shift of six hours of direct patient care to two hours of indirect care. In determining the cost of a clinical care unit, payroll dollars for direct and indirect care as well as nursing department overhead and inpatient physician costs included with direct patient care. That figure becomes the numerator, into which we divide the number of clinical care units we expect to deliver in the budget year, and the resulting figure is the cost of a single clinical care unit.

The split cost accounting system is a significant tool for stabilizing hospital budget forecasts. Presently, hospital administrators have a single figure with which to work, the all-inclusive "per diem" room date. In this "per diem" system, unexpected declines in patient days can lead to serious "block" revenue losses. With the split cost accounting system of the Massachusetts Eye and Ear Infirmary, there are three "cost" categories with a potential for adjustment; (1) per patient revenue from one-time hospitalization charge (related to number of discharges), (2) revenue from clinical care units charge (related to the intensity of clinical care given), and (3) the real per diem of "hotel" charges. With the old "per diem" system, it is extremely difficult to identify problem areas, and therefore when adjustments are indicated there is the danger that adjustments will be made in the wrong places. With the split cost accounting system, however, we can easily see which areas are affected by changes in volume, and adjustments can be made accordingly.

The split cost accounting system, by isolating cost centers, presents a more accurate financial picture of an institution than the traditional accounting system in general use. As we said, this new method of cost accounting lends itself to effective budget forecasting. Cost centers can be isolated for the predicted number of patient discharges for the coming year, and accurate figures can be extrapolated for budgeting purposes. Taking this one logical step further, since we can prepare accurate budget forecasts, based on this split cost accounting system, we have the credibility and confidence to enter prospective reimbursement programs with third party payers.

Happily enough, the results of the first year seem to bear out our thesis that health-care providers and insurers can join together and come up with a cost accounting system that accurately and equitably apportions cost for varying levels of care, supplies critically useful information that can lead to more efficient use of services and facilities and, ultimately can help slow the spiraling cost of medical care. Our system is not all things to all people, but it is these things to these people: a charge system that can be made to make sense to the public; a fair cost-for-service-rendered system to the health-care consumer; a clear representation of hospital accounting to government regulative and legislative bodies; and a highly useful management tool for health-care administrators. Our first year's experience has also demonstrated how desirable it is from both economic and programmatic points of view to treat single spells of illness within a single institution. This point has not been made clear before but follows. The Massachusetts Eye and Ear Infirmary is living proof that acute-care facilities can successfully offer economical care below the acute-care level since the system allows patients receiving maintenance-level nursing care to pay a minimum, not an average, charge.

Management information made available through the split cost accounting system has made possible new approaches throughout the broad spectrum of hospital operations. In the sections that follow some of the far-reaching potentialities of the interrelated programs which relate to the Massachusetts Eye and Ear Infirmary split cost accounting system are explored in some detail.

The Infirmary system allows us to identify accurately the cost of keeping a patient in our hospital as his clinical care needs are reduced. Once a patient has paid the one-time hospitalization charge, the ongoing charges consist only of the rate per patient day, and charges for the clinical care units he or she continues to require. If, for example, a patient toward the end of his or her stay needs only 5 clinical care units each day, at the Infirmary's 1977 Fiscal Year rates, having paid the one time hospitalization charge of \$202.69 he or she can stay on at the Infirmary for \$41.25 per day plus \$22.70 (or five times the clinical care unit charge for clinical care), or a total of \$63.95 a day. This figure compares favorably with the daily charge in many skilled nursing facilities, with the great added advantage of reducing duplication, inefficiency, and inconvenience.

As I mentioned earlier, we were highly optimistic about the program before its inception, and our confidence grew during the courses of its first test year. The accompanying illustrations show the "returns" from our first year, and every indication is that the basic elements of the program, and the side benefits evolving along the way, are reliable. The program has attracted considerable attention from all of the sectors that could be affected by it: the general public, hospital administrators, physicians, health-care groups, insurers, and government organizations of various kinds at various state and federal levels.

In recent months there has been some interest expressed in the methodology for adapting the cost accounting system described herein to general hospitals. In response to this, I would like to say most emphatically at the outset that I believe the method of cost accounting outlined in this article can indeed be successfully adapted to any level and any size of general hospital.

The categories of the cost accounting system which we call "Cost per Patient" and "Cost per Patient Day" can easily be translated to a general hospital framework, since we are really speaking simply of the allocation of certain cost centers by category. The development of a clinical care unit system for a general hospital perhaps requires more explanation here.

The clinical care unit system in use at the Massachusetts Eye and Ear Infirmary is based on averages. It was built by determining average levels of care by diagnosis by day. General hospital diagnoses would be studied in much the same manner as we originally studied our specialty hospital diagnoses. The key work is, of course, averaging. The average level of care by day of illness for patients with, let us say, colitis, would be determined just as we ourselves determined the average level of care by day of illness for patients with detached retinas. One suggestion would be for a general hospital to identify the relatively few diagnostic categories that will comprise the vast majority of its admissions and build a data base on these, leaving the remainder in a category of "other", which would in turn have its own clinical care curve.

Clearly, I am not saying that each individual patient is to be stopwatched and then billed for exactly the amount of nursing care he or she receives. This kind of a system would, in my mind, be so complicated and impossible to monitor (particularly from the point of view of a third party reimbursor) that the effort put in would exceed the benefit received. I believe, though, that the traditional system of averaging all patients within a hospital regardless of diagnosis and of intensity of care required, can and should be replaced. What we have tried to design is a system that averages in what I feel is a far more accurate and relevant way . . . that is, by diagnosis by day, based on relative work effort in terms of clinical care requirements. It seems to me that if we are able to average diagnostic data by length of stay for purposes of utilization review, we can average that same kind of data for purposes of producing a more efficient and equitable cost accounting system.

The fact that there has been some widespread interest in our program is an indication to us at the Infirmary that the public and private sectors are both seriously concerned with bringing antiquated methods of accounting for health care charges up to date. Whether the answer is our system transplanted elsewhere—and, as I said we are convinced it can work in almost any health-care institution—or some similar outgrowth of this new and important dialogue, the result can only be a welcome and long-needed improvement in service to our patients and to health care in general.

STATEMENT OF JOHN B. SMITH, MEDICAL PERSONNEL POOL, FORT LAUDERDALE, FLA.

My name is John B. Smith, legal and legislative counsel for the Medical Personnel Pool Division of Personnel Pool of America, Inc., a national nursing and home health care service. Medical Personnel Pool is a proprietary organization with 109 offices nationwide. In 1976, the company delivered approximately 11 million hours of nursing and home health care services. The 109 offices employed approximately 41,000 professional and staff personnel, averaging 376 employees per office.

Medical Personnel Pool firmly supports the intent of S. 1470, the Medicare and Medicaid Administrative and Reimbursement Reform Act, to cut hospital and health costs.

There are two basic ways to cut or contain hospital costs: encourage alternatives and expand variable hospital staffing.

Variable staffing reduces payroll costs, which can run as high as 66 percent of the total cost of running a hospital, because variable staffing allows the facility to staff according to daily requirements. There is instant flexibility to increase or decrease nursing staff as the hospital census fluctuates over any given range. In fact, the wider and more frequent the census variation, the greater the savings to the hospital.

Simply put, variable staffing means staffing with permanent nursing personnel to the hospital's average census figures. The institution then relies on supplemental nursing help from a source like Medical Personnel Pool to supply needed personnel as the census level increases, and cancels that help as it decreases. The institution pays only the cost of supplemental help when it is required and can eliminate the cost of excess permanent personnel. Medical Personnel Pool has been a pioneer in this area.

HEW Secretary Califano recently testified that one million dollars per day are being wasted on patients who are unnecessarily in acute care hospitals. (This figure dwarfs the five million dollars being considered in the Senate for home health agency expansion and training grants in the fiscal 1978 HEW budget.) Industry estimates of unnecessary nursing home utilization range from 15 percent to 80 percent of the patients, with opinions clustered at the 25 percent figure.

In the range of alternatives to institutionalization, Medical Personnel Pool is one of the country's primary resources for home health care.

Medical Personnel Pool has supplied or is supplying personnel and services under Title XIX and XX of the Social Security Act, under the Older Americans Act and to Visiting Nurse Associations in various parts of the country. For instance, we are supplying home health aides to VNA's located in Detroit and Lansing, Michigan; Morris Plains, New Jersey; Orlando, Florida; South Bend, Indiana; Milwaukee, Wisconsin; Rochester, New York; and in other locations. In Detroit, we are currently providing 30 home health aides per week and will be increasing that number dramatically this fall at the request of the VNA. We have assisted the Milwaukee VNA in modifying and improving their home health aide training course.

In addition to supply the VNA's with home health aides, we have provided them with staff nurses in several cities throughout the country. Similar services are provided to state and county welfare departments, health departments and hospitals. For over two years, we have been a provider to the experimental TRIAGE program in Hartford, Connecticut.

Medical Personnel Pool believes that the extent of the company's involvement in government health programs proves that our services are of a high quality and that they are needed.

While we prize our working relationships with Visiting Nurse Associations through subcontracting, we believe that their need to subcontract for services demonstrates a lack of availability of home health care services in the Medicare-certified sector. If the services were available directly through existing certified agencies, or if the cost of developing such additional services were less, there would be no need to utilize subcontracting arrangements with the proprietaries.

Proprietary home health agency participation in federally-supported health programs including Medicare, Medicaid, Title XX Social Services and the Older Americans Act, whether as direct or indirect providers, is increasing as the population's demand for home health care increases. This is despite the fact that the Social Security Act's Section 1861(o) restricts Medicare certification to nonprofit agencies and licensed proprietaries. Only 17 states have enacted home health agency licensure laws.

The federal government's inaction on this discriminatory statute, coupled with the Bureau of Health Insurance policy of allowing proprietary participation through subcontracting, seems to indicate an acknowledgement of the need for tax-paying resources but a lack of desire to legitimize and control them.

In our view, a policy of encouraging the certified agencies to subcontract with proprietaries, instead of allowing them to become direct, certified providers dilutes, extends and duplicates lines of communication and authority. Standards of quality care, personnel training, efficiency and employee accountability are more difficult to implement and enforce.

Further, administrative costs of the certified contracting agencies are superimposed on the cost of the subcontracted service, thereby increasing total program costs.

If tax-paying home health agencies are being restricted as a second tier provider because of fears of their level of quality, we submit that in virtually every hearing exploring this issue during the last two years, the record attests that there is no difference in quality between proprietaries and nonprofits. This holds true even in the fraud and abuse hearings conducted by Senator Chiles on private non-profits and the Ways & Means Oversight investigation of two California proprietaries.

Controls for quality must lie in a set of enforced, uniform standards applicable to all agencies. We urge the Senate Finance Committee to look closely at Rep. Cohen's H.R. 6299, which mandates a one year program to enact uniform standards for home health agencies. His bill, in diluted form, is attached to H.R. 3, the Anti-Fraud and Abuse bill, now under consideration by the House Ways & Means and Interstate and Foreign Commerce Committees.

It is argued that quality control ought to be the purview of Certificate of Need programs. Look at what has happened in Florida, where this philosophy has been enacted into law.

In the spring of 1976, Senator Lawton Chiles of Florida held investigative hearings in Miami and Tampa which detailed certain practices of private nonprofit home health agencies.

His investigation exposed a widespread practice of private nonprofits essentially distributing profits in the form of inflated administrative salaries and benefits—all paid for by Medicare (which pays all costs for Medicare patients) through the simple expedient of turning away any patient who was not covered by Medicare.

The Florida legislature enacted a law that required licensure of home health agencies effective July 1, 1975. This law also required that the agency secure a Statement of Need from the local health systems agency before it could get a license.

In the closing minutes of the 1976 legislative session, Senator Tom Gallen introduced an amendment that grandfathered all home health agencies that had Medicare provider numbers. The grandfather amendment states that any agency with provider number before April 30, 1976 is exempted from Statement of Need requirements.

The state of Florida has, through this action, instantly legitimized and exempted from control, the very private nonprofits which caused the fiasco Senator Chiles exposed. While accepting these comparatively newly-established agencies, the state, through the grandfather clause, excluded the proprietary agencies which have been running legitimate businesses in Florida for some ten years.

As you might expect, we are having a great deal of difficulty obtaining Statements of Need, since these private nonprofits lobby heavily or actually sit in key positions with the health systems agencies, and can delay or prevent proprietaries from entering their "market." The reason for these tactics? Simple. They cannot compete with the services cost or quality of nursing care provided by for-profit organizations like Medical Personnel Pool.

Until recently, Medical Personnel Pool did not wish to become Medicare-certified—the Medicare home health benefit is restrictive in terms of fitting care to the patient's need and overburdened with paperwork which makes it an expensive program to administer. More importantly, the Medicare rule of reimbursing the lesser of cost or charge meant that we would lose our private patients, who cannot afford to pay Medicare rates inflated by artificial cost components based on the institutional system of cost finding allowances.

However, the certificate of need situation, coupled with requests from some state health departments who need us as Medicaid providers has caused us to seek Medicare certification.

Medical Personnel Pool sees the Medicare/Medicaid home health benefit problems outlined in our testimony as fertile ground for S. 1470 action.

We urge the Senate Finance Committee to recognize the growing Congressional realization that home health care is the wave of the present. If S. 1470 is going to provide incentives to hospitals for shifting and cutting down bed usage, it ought to provide for the increased demand for home care that will be generated by the displaced patients.

The two first steps in providing for increased availability of home care services are to enact a uniform set of standards applicable to all home health care providers and to delete the Section 1861(o) definition which discriminates against tax-paying providers.

STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC. ROBERT H. SWEENEY, EXECUTIVE DIRECTOR

The member institutions of The National Association of Children's Hospitals and Related Institutions, Inc., more easily stated as NACHRI, register 87 percent of admissions to all Children's Hospitals.

Through the Association, they address their dedication to the improvement of Child Health services and express a collective advocacy for the Health Care needs of Children.

In the year ended September 30, 1976, the 123 Children's Hospitals admitted 370,000 patients; recorded 3.9 million outpatient visits; and expended an estimated \$750 million in the care of this Nation's children. The total assets devoted to this program of service exceed \$1.2 billion.

In addressing S. 1470, the Association does not intend to comment on its effects on Children's Hospitals as hospitals per se, but rather on its potential consequences to the ability of these institutions to provide specialized health services to children.

All the members of this Association are also members of the American Hospital Association. They should, and do, look to that Association to provide their representation as members of the hospital community. As NACHRI does not attempt to replicate AHA's program, it shall not attempt to duplicate its testimony on this proposal, but rather call the attention of Children's Hospitals to it, for their consideration of support.

NACHRI's statement, then, speaks to the perceived effect of S. 1407 on the delivery of health services to children.

In sharp contrast to S. 1391, "The Hospital Cost Containment Act of 1977), S. 1407 recognizes that hospitals are not the same, with exception of size and geographic location.

This Association has stated publicly, to the appropriate House Subcommittees, its deep concerns about the effects of S. 1391 on effective Child Health care and its apparent insensitivity of its consequences to children.

S. 1407 provides, in Sec. 2, for an appropriate system of classification of institutions which will be reflective of size, the inferences of program, teaching responsibilities, geographic variances in cost exposure; and indeed, unusual circumstances within a specific category of hospitals.

Further, it is encouraging to note that the Secretary, HEW, is directed to consult with appropriate National organizations prior to establishment of the described system of hospital classification. This Association stands ready to participate in such discussions.

The average Children's Hospital in this country has 106 beds, the largest having 343. Of the 70 short-term Children's Hospitals, which will be more directly affected by this proposal, the average bed size is 143. The typical short-term Children's Hospital is a regional referral center, providing a variety of sophisticated medical services for children and youth of a multi-county and frequently a multi-state area.

To these institutions are referred the most complex, the most involved patients, for whom neither the high intensity of care nor of specialization is available in the local community; nor does the incidence of any particular illness indicate that it should be.

A more simplistic system of classification of hospitals, such as that developed in response to Sec. 223, P.L. 92-603, which S. 1407 is designed to replace, would result in the comparison of the majority of these Children's Health Centers with the 1,363 general hospitals in the 100-199 bed size category, whose main mission is the essential, but less complex and less costly, provision of routine hospital services.

As just one indicator of difference in response to patient needs, these 100-199 bed general hospitals employ 2.3 personnel per bed. The short-term Children's Hospitals employ 4 employees per bed in order to meet the needs of the child and the sophisticated procedures which the causes of his hospitalization demand.

It is encouraging to note that S. 1407 exhibits awareness of these differences inherent in the hospital care of children, by authorizing the Secretary to establish classification category or categories for "psychiatric, geriatric, maternity, pediatric, or other specialty hospitals, as the Secretary may determine appropriate, in light of any differences in specialty which significantly affect the routine costs of the different types of hospitals".

Recognizing that the intent of this proposal is to create a credible system of classification that is objective in its expectations, and precise in its definitions, two suggested improvements to Sec. 2 are offered:

(1) The Secretary's determination of the appropriateness of such categories should be on the basis of detailed, objective, and factual studies of the program characteristics and resultant costs of such institutions; and not upon any subjective conclusion that costs at variance with those of a majority of hospitals whose only similarity is size are indication of "obesity" within the health care system.

In the implementation of Sec. 223, P.L. 92-603, 15 months elapsed between the promulgation of reasonable cost ceilings which, by statute, affected Medicaid-only providers, and development of the exception process which would allow such providers to seek relief from cost ceilings which were inconsistent with their cost exposure. In that interim, Children's Hospitals suffered reimbursement considerably less than the cost of provision of services, with a deteriorating effect on cash flow.

To avoid repetition of such a circumstance and to encourage prompt implementation of the Congressional intent, it is recommended that the Specialty Hospitals enumerated not be subject to the cost categorization described until such studies have been conducted and the Secretary's determination made.

This recommendation is made, not in an effort at evasion, but rather to prevent the repetition of a similar period of fiscal hardship which will endanger the ability of these institutions to meet the needs of patients, for many of whom they are the singular indicated source of needed care.

Indeed, this Association has begun just such a comprehensive study, the results of which will be available and readily shared with the Secretary for use in his determination of the cost exposure of Children's Hospitals.

(2) Use of the term "Pediatric", in defining those hospitals which care solely for children is compromised by the imprecise definition of the word itself. "Pediatric", through usage, has come to identify a relationship with, or orientation to, the particular medical specialty of Pediatrics. As such, its employment in the context of S. 1407 might be perceived to indicate exclusion of Children's Orthopedic Hospitals, Children's Rehabilitation Hospitals, Children's Respiratory Disease Hospitals, etc., and their consequent classification by bed size alone.

The cost exposure of these hospitals results from response to the needs of their patients, not the specialty of those who attend them.

To continue the precision of effort so evident in the language of the proposal, it is, therefore, recommended that this identification be changed from "Pediatric" to "Children's".

It is encouraging to note that S. 1407 reflects awareness of the cost consequences of a hospital's teaching responsibilities, by its creation of a classification for those "hospitals which are the primary affiliates of accredited medical schools (with one hospital to be nominated by each accredited medical school)".

This demonstrates recognition of the compounded cost consequences of such activities; the cost of the education process itself, and the increasingly complex clinical challenges which are referred for treatment to such institutions.

The definition of a special category for Children's Hospitals might be perceived to speak to the needs for proper consideration of the teaching Children's Hospitals; and, since the vast majority of Children's Hospitals are actively engaged in teaching programs, the aggregate costs of that category will reflect the consequence of such activities.

Further, it is recognized that S. 1407 provides for consideration of the individual situation, wherein "the hospital satisfactorily demonstrates that its patients require a substantially greater intensity of care . . .".

There are Children's Hospitals, in major metropolitan areas of the country, however, whose patient referrals are not merely regional, but indeed national or international as a consequence of their intensive teaching, research, and clinical activities. These Children's Hospitals would appear to be potential re-

peated annual petitioners of the Secretary for such consideration, at considerable cost to the petitioner for preparation of such appeal; and to the Federal government for its consideration.

In recognition that S. 1407 seeks cost effectiveness in administration of its provision as well as in the hospitals affected, two recommendations are presented:

(1) To Sec. 1861 (aa) (4) (F) be added: "In the interest of effective administration, upon satisfactory demonstration by a hospital, the Secretary may reclassify the hospital to another category appropriate to such unusually greater costs hereby demonstrated".

(2) That Sec. 1861 (aa) (91) (B) (ii) (II), describing that category of hospitals which are primary affiliates of medical schools be modified to permit, at the option of the Secretary, recognition of the circumstance of teaching specialty hospitals; i.e., that for the clinical specialty involved the hospital's program and resultant cost exposure are as great as those of the single designated primary affiliate.

The Medical Schools with which many Children's Hospitals are affiliated have no Pediatric service within the general hospital which is their prime affiliate. To the affiliated Children's Hospital accrue the intensity and cost of the Pediatric service. With incorporation of these two modifications, the Secretary would be able to shift these Children's Hospitals of particular intensity to a more appropriate peer group classification; thus, an administrative process will exist for recognition of unusual operating costs which will be less complex and costly to institution and the Federal government alike.

S. 1407 also provides for expansion of the determination of reasonable costs to other reimbursable hospital services, and sets general parameters for the comparison among providers of the resultant costs. Omitted, however, is specific recognition of patient characteristics which is so evident in the separate categorization of specialty hospitals for routine cost determination.

It is recommended that the bases for comparison among providers be expanded to include such recognition, lest this determination of reasonable "other costs" slip back into the simplistic quantitative process so evident in the Sec. 223 implementation.

Similarly, NACHRI would urge that the Secretary's agreement with the States, for conduct of a hospital reimbursement system, require that recognition of the Specialty Hospitals cost exposure, for both routine and other costs, be evidenced and be a part of such system.

Finally, the Association notes with appreciation the inclusion of Sec. 42, authorizing grants for Regional Pediatric Respiratory Centers.

Chronic respiratory disease is the leading cause of disability among children. Asthma and bronchitis affect 70 of every 1,000 persons under 17 years of age, more than twice the incidence of those affected by heart conditions, hearing impairments and vision impairments combined. Untreated, it leads to chronic disability and shortened life expectancy. Its treatment and prevention through programs of training of health care personnel and clinical services will prove most cost effective, by allowing young persons to lead productive lives and be contributors to society, rather than being dependent on it.

NATIONAL ASSOCIATION OF MANUFACTURERS,
INDUSTRIAL RELATIONS DEPARTMENT,
Washington, D.C., June 20, 1977.

HON. HERMAN A. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR CHAIRMAN TALMADGE: The National Association of Manufacturers is a trade association composed of some 13,000 member manufacturing organizations representing seventy-five percent (75%) of those employed in industry. As the representative of this vast number of health care users, employers who provide health care protection to these employees and their families and of this great number of taxpayers who must bear the cost of Medicare and Medicaid, we welcome the opportunity to comment on S. 1470.

Speaking for American industry, the NAM is extremely concerned about the problem of escalating health care costs. We continue to believe, as we have stated in the past, that the achievement of reasonable cost levels in Medicare and Medicaid are an absolute requisite before Congress considers any form of National Health Insurance legislation.

We believe that the problem of health care costs, in both the private and public sectors is an issue of such extreme complexity that there is no single solution. We congratulate the sponsors of this bill for the conscientious and apparent intensive research into the problems of the Medicare/Medicaid programs and for their courage to attack the difficult problem of Medicare/Medicaid cost escalation.

Subject to the resolution of the spill-over problem, the NAM supports S. 1470 in general. The approach of S. 1470 is basically one of incentives which is entirely consistent with industry's position on cost containment.

COMMENTS ON SPECIFIC ISSUES

1. Hospital reimbursement reform

We strongly support the use of incentives to control health care costs. This bill establishes a method and applies the method to reimbursement for routine operating costs, leaving open the problem of other costs until the approach has proved itself. We support the idea of working on the problem in stages and using the knowledge developed in finding answers to questions which arise as the program is extended.

We encourage the indexing of hospital facilities to allow appropriate comparisons to be made. We support the establishment of a uniform cost reporting system and commend the sponsors of the bill for the specification of at least a six month period to react to proposed systems. There is no question that any effective reporting system must be developed with full input and consideration of the views of those who are affected by and will have to live with the system.

The NAM is seriously concerned that the exemption procedure contained in S. 1470 may not be able to be implemented without encouraging further abuse. The very broad definition of unusual costs may create an opportunity for those who most need to examine their cost to be exempted from the provisions of this Act. To minimize the opportunity for abuse, we recommend that the state and regional health planning agencies established under PL93-641 be given an effective role in the exemption process.

2. State reimbursement systems.

We fully agree that where State hospital reimbursement systems result in lower aggregate payments to hospitals in a state than the system established by S. 1470, that the state system can be retained. We have already seen gratifying progress in hospital cost reduction in several states, particularly Maryland and Connecticut. Such efforts should not be discouraged by federal surplantation when they are about to mature as effective agencies. In addition, effective state review systems can permit the development and testing of alternative payment methods and the evaluation of their effectiveness.

3. Payments to promote closing and conversion of underutilized facilities

We agree that hospitals which are ill-needed should be closed or diverted to some other use. In general we feel that the federal government should not pay the cost of overbuilding. Being somewhat cautious of subsidies for non-production along the lines of the recently discontinued farm subsidies, we are glad to see the two year trial period on this issue. Very close oversight in administration of that section of the bill must be continued. Public hearings should be held at the close of the original two year period so that those representatives of the public who have an interest in this legislation are afforded an opportunity to report on their experience with it.

4. Federal participation in hospital capital expenditures

NAM has consistently supported the development of health planning systems and encouraged its members to serve in them. These new organizations must be given a significant role in health care cost control and the support and training to carry out that role.

5. *Use of approved relative value schedules*

We genuinely believe that the development of a common language to describe the kinds of services covered under public and private health benefit plans will provide a more rational basis for evaluating benefit plans and the fees charged for services. The development of a terminology system will go a long way to support the salutary effects of the uniform reporting systems.

6. *Establishment of health care financing administration*

The NAM shares the concern of the eminent chairman of this Committee for the efficiency of the new health care agency that the original aims of this reorganization may be lost. So we support the standby powers this bill contains. **This existence may do much to ensure that they are never needed.**

We are particularly concerned that the cost of containing health care costs not exceed the money saved. Therefore, we reiterate our previous recommendation that budget and staffing for the Central Fraud and Abuse Control Office be tied to a percentage of the recoveries achieved through that office after its first three years of operation.

7. *Disclosure of aggregate payments to physicians*

We also support the provisions of Section 44 which prohibit the release of the names of physicians who have been paid large amounts for treating Medicaid patients. Publication of such a list implies some abuse where in most cases none exists. Without it, the physicians who honestly are devoting their professional hours to those on Medicare would risk their reputations that most and many doctors may be discouraged from accepting any Medicare patients. Beyond that it is contrary to the American system of justice to make implications about a person's honesty without affording that person a chance to reply.

8. *Spillover effect*

We deeply appreciate the fact that the sponsors of this bill have included in this version of the bill language which prohibits health providers from passing on to the private sector any excess expenses which result from tightened cost control under the Medicare and Medicaid programs, which we asked for in our comments on S. 3205 last year. However, the bill does not contain a mechanism for enforcement of that restriction. We believe that if such mechanism is not developed for controlling the spill-over effect, NAM will be unable to support the bill.

In summary, the NAM supports many of the objectives of S. 1470. We do believe that the absence of a mechanism for enforcement of the restriction for spill-over to other health providers is so serious and of such concern to industry that an adequate provision must be included before we can support S. 1470 in its entirety.

Sincerely,

RANDOLPH M. HALE,
Vice President and Manager.

NIGHTLETTER FOR AMERICAN MEDICINE,
Los Altos, Calif., June 13, 1977.

Senator HERMAN TALMADGE,
*Subcommittee on Health, Senate Finance Committee, Senate Office Building,
Washington, D.C.*

DEAR SENATOR TALMADGE: "Apple Pie & Everything Sweet" which appeared in V. II, #1 of the Nightletter for American Medicine is an analysis of S. 370 which I believe is germane to your interests and to those of the Subcommittee on Health.

You have already noted in your perspicacious remarks on S. 1470 that good ideas may become "bogged down in the quagmire of bureaucratic self-interest." That is what has happened also with S. 370. Here's how:

HEW is so anxious for new tiers of bureaucracy that it is has helped erect an entirely new Board within the confines of S. 370—this new Board is to be the Board of Maternal and Child Health, or, as it now stands, the Maternal and Child Health Board which will operate within the confines of HEW, or within the constraints of HEW's allowances and tolerances. Note that Secretary Joseph A. Califano of HEW has no great worries in setting up this still another level of "red tape." What has happened to President Jimmy Carter's promise to eliminate "red tape"?

HEW is so anxious, in fact, for these new levels of bureaucratic red tape that has in most unseemly fashion collaborated with vested academic interests within medicine to achieve its ends. For instance, key provisions within S. 370 appear to have been dictated by the New York Academy of Pediatrics (Sen. Javits' Jake Cutler apparently doing the actual direction of the subsequent drafting) and by the American College of Obstetrics & Gynecology. In allowing vested interests within the academic framework of medicine (but not necessarily one bit more scholarly because of the academic association) to develop key parts of S. 370, Secretary Califano has at least guaranteed that HEW will have some support for S. 370 from within the framework of organized medicine. Bureaucratic self-interest is served in this way—with a piece of the pie indignantly tossed to a very limited spectrum of self-serving academic interests, O.

Yours truly,

ROBERT L. WEINMANN, M.D.
Editor and Publisher.

STATEMENT OF THE PUBLIC CITIZEN'S HEALTH RESEARCH GROUP

INTRODUCTION AND SUMMARY

The Health Research Group opposes the enactment of S. 1470. Although some of its provisions, notably the allowance of Medicare and Medicaid reimbursement for the closing and conversion of underutilized hospital facilities, have merit, we believe the scope and significance of the reforms contained in the bill are much too limited to have any appreciable impact on the billions of dollars now being wasted through unnecessary or inefficiently delivered hospital services. S. 1470 makes only extremely minor changes in the open-ended, retrospective, cost-based, fee-for-service reimbursement system which is the root cause of waste in the health care system.

Following is a brief summary of our comments on selected provisions of the bill:

1. Any cost containment strategy which applies only to Medicare and Medicaid will not save money but will penalize Medicare and Medicaid recipients.
2. Section 2: The changes in hospital reimbursement apply only to a small fraction of the hospital budget, exclude those services which are inflating most rapidly, encourage increases in length of stay and admission rate, use inappropriate classification criteria, and retain most incentives for higher spending. We support the establishment of a uniform accounting system.
3. Section 3: Payments to promote closing and conversion of underutilized facilities are desirable but should be subject to approval by state and local planning agencies.
4. Sections 10 and 11: The minor changes proposed for Medicare physician reimbursement will not solve existing problems in the assignment system or geographic disparities in fees or physician distribution.
5. Section 12: While elimination of the percentage payment system for hospital-based physicians is desirable, fee-for-service payment should also be eliminated in favor of salaries.
6. Section 43: The waiver of the application of human experimentation protections to Medicare and Medicaid must be deleted.
7. Section 44: The prohibition on public disclosure of aggregate payments to physicians must be deleted.

GENERAL COMMENT

A general and fatal problem with S. 1470 in its present form is that it applies only to Medicare and Medicaid, which together account for only about one third of all hospital spending. Experience with cost controls limited to public programs, particularly with state Medicaid programs, demonstrates that aggregate health care expenditures are not contained. Instead, access to services needed by the poor or elderly is restricted and/or the costs of providing care to the poor are merely shifted to local taxpayers or private patients. Providers will respond to limitations on reimbursement for public patients by refusing to serve them, by providing additional unnecessary services to compensate for lower fees, or by

charging private patients more to subsidize their Medicare and Medicaid patient load. In short, there will be no overall cost containment, public patients will be arbitrarily denied needed services, and private sector costs will increase more rapidly than ever.

Section 2. Criteria for determining reasonable cost of hospital services

This provision is intended to encourage hospitals to be efficient by basing the reimbursement system on the average costs of comparable hospitals. However, because of the way payment rates are calculated, which only slightly modifies the reasonable cost system, there is no assurance that any money will be saved or that the incentives created are more desirable than those now in existence. Aside from the fact that these reforms apply only to Medicare and Medicaid, they suffer from the following flaws:

1. The reimbursement changes apply only to "routine operating costs." Estimates are that only 30-40 percent of all hospital costs are covered. Since Medicare and Medicaid only pay for about one-third of all hospital care, the component of aggregate hospital expenditures which is covered is only about 12 to 13 percent. Only about 7 or 8 billion dollars, or about 5 percent of all health care expenditures, could possibly be affected by the bill. The Congressional Budget Office estimated that if S. 3205 (the 94th Congress bill with essentially the same reimbursement provisions) had been in place during fiscal 1977, only \$150 million would have been saved. To put this amount in perspective, consider that it is equal to about 70 cents per capita at a time when total annual health care costs are about \$700 per capita—i.e., spending would be reduced by 1/10 of 1 percent.

Furthermore, what is excluded from routine operating costs contributes disproportionately to hospital cost increases. One study found that more than one-third of all hospital spending increases are a result of increases in volume of nine ancillary services (not counting increases in cost per unit).¹ Therefore, routine operating costs account for much less than 35-40 percent of the increase in hospital costs. Indeed, it would be far more effective to control such items as ancillary services and capital costs and exclude routine operating costs rather than vice versa.

2. The payment system is based on a per diem rate. Although this is intended to encourage reductions in cost per patient day, it will also create an incentive to increase the volume of patient days to compensate for the price controls. There are no incentives included in the bill which would discourage volume increases (as there are in the Administration Cost Containment bill, for example), nor is there any limit on the aggregate hospital budget or any component thereof. Thus, this approach is likely to have the counterproductive result of increasing average length of stay and perhaps also the hospital admission rate. Because of such increases in utilization, some state rate-setting programs were initially ineffective. Lower per diem rates were offset by an increase in patient days, and no savings were achieved.

3. The criteria used for hospital classification—bed size and medical school affiliation—are at best indirectly related to legitimate differences in costs. Both are surrogates for variations in the sickness of patients. There is no intrinsic reason why bigger hospitals or medical school hospitals (when teaching costs are excluded) should have higher routine operating costs. Until HEW has the necessary data to classify by diagnosis and perhaps age of patient, it is questionable whether a system which locks in existing cost differences by hospital size should be implemented.

4. The reimbursement system of Section 2 is based on the average per diem routine operating cost of each category of hospital with an adjustment for geographic variations in wage rates. Hospitals will continue to be paid on the basis of reasonable costs, except that they cannot be paid more than 120 percent of the average for their category. If their costs are less than average, they can retain half the difference, up to 5 percent of the average rate. While this approach would seem to contain desirable incentives, its actual impact on costs is problematical.

The bill assumes that some hospitals are inefficient but fails to recognize that these inefficient hospitals artificially inflate the average. Also, it is not at all clear that a hospital manager has an incentive to reduce costs.

¹ Redisch, "Hospital Inflationary Mechanisms," October 1974 (unpublished).

Indeed, there are several reasons why most hospitals will continue to want to spend more rather than less. First, it is in the collective interests of the hospitals in any category to increase spending in order to raise the average used to calculate next year's rates (which are re-calculated each year). Second, the "spend-more-get-more" system is still operative up to 120 percent of the average (which, as mentioned above, is already too high). Third, all the non-financial incentives to increase the intensity of services, such as pressure from medical staff and trustees, are still present.

On the other hand, the incentive for spending less is comparatively weak. The largest bonus that the typical hospital can retain will be 5 percent of routine operating costs for Medicare and Medicaid (about 12 percent of the total budget, as discussed above) or about 6/10 of 1 percent of the total budget. Also, since most hospitals are non-profit, the incentive payment can't be extracted from the hospital in the form of dividends in any event. It could only be used to provide a minor subsidy for money-losing services or accumulated for capital expenditures, which may be unnecessary. Thus, it would appear that, with the possible exception of those hospitals already 10 percent or more below average and those more than 20 percent above average, hospitals will continue to have both monetary and non-monetary reasons to spend more.

Finally, the new system would not take effect until fiscal 1981. In the interim, all hospitals will have a powerful incentive to elevate their spending in order to maximize the average used to determine the initial payment rate. It is likely that the rate at which hospital costs inflate, already intolerably high, would be even higher for fiscal 1978, 1979, and 1980.

5. We do support the requirement which would be established by section 1861 (aa) (1) (A) for an accounting and uniform functional cost reporting system. We recommend that it include clear identification of how much charity care, as opposed to bad debts, the hospital is providing.

Section 3. Payments to promote closing and conversion of underutilized facilities

We support the concept of providing the reimbursement necessary to cover the costs of closing or converting underutilized hospital capacity. However, we believe that no facility conversion should be qualified unless and until it has received the approval of the State Health Planning and Development Agency, after review and recommendation by the local Health System Agency. Also, consideration should be given to an amendment which would discontinue all federal reimbursement except for the "transitional allowance" to any service which is found inappropriate by the SHPDA under section 1523(a) (6) of the Public Health Service Act. States are not required by that provision to sanction services found inappropriate.

Section 10 and 11. Physician reimbursement under medicare

While we support the attempt to encourage physicians to accept assignment for Medicare patients, we would recommend that assignment be mandatory (as it is for Medicaid) and that the physician reimbursement system be reformed in other ways to assure that all Medicare and Medicaid patients will have access to physician services.

The other changes in physician reimbursement contained in section 11 would make the calculation of allowable physician payment even more complicated than it already is, without significantly alleviating geographic disparities or maldistribution or achieving significant savings. All of these issues are dealt with in much greater detail in our report "Why Not the Most?", a copy of which has already been made available to Senator Talmadge.

Section 12. Hospital-associated physicians

We agree that percentage or lease arrangements between hospitals and hospital-based physicians have resulted in exorbitant payments to physicians often unrelated to actual services directly provided by the physician to patients. The percentage system also creates strong incentives for the hospital-based physician to maximize the volume of services he delivers. The volume of ancillary services such as lab tests and X-rays has increased at an alarming rate in recent years, as discussed above, in response to this incentive. However, the bill preserves the fee-for-service system, which contains exactly the same incentive. In fact, to the extent that fees are lower than percentage payments, hospital-based physicians are likely to respond by increasing volume even more.

The best solution would be to recognize that hospital-based physicians are monopolists with considerable ability to control the volume of services their departments deliver and to require any hospital participating in Medicare and Medicaid to pay them on a salary basis.

Section 43. Waiver of human experimental provision for medicare and medicaid

This provision would prevent the application of the law requiring protection of human experimental subjects to Medicare and Medicaid. The change was motivated by a court ruling which held that a Medicaid cost-sharing program in Georgia was a human experiment to which this law applied. This proposal demonstrates a callous insensitivity to the poor and elderly people who must rely on Medicare and Medicaid. The bill would subject the most vulnerable group of people in the population to any human experiment conducted with Medicare and Medicaid funds without the protections mandated by Public Law 93-348. Not only must this provision be deleted, but the provision in Title XIX which allows cost-sharing in state Medicaid programs should be amended to *prohibit* cost-sharing. Medicaid recipients are by definition without ability to pay. Cost-sharing denies them needed services on the basis of their income.

Section 44. Disclosure of aggregate payments to physicians

It is unfortunate that disclosure of aggregate payments to physicians under Medicare and Medicaid has been characterized by inaccuracies and has sometimes misled the public to believe that the amounts were net income rather than gross income and that all physicians on the list were abusing the programs. However, we strongly oppose any provision which would prevent public disclosure of information about the charges, quantity, or quality of services of any physician participating in Medicare and Medicaid. Indeed, we believe that disclosure of physician-identifiable data should be expanded to include customary fees for particular procedures and data on utilization and quality collected by PSROs. We urge that section 44 be deleted from the bill.

WASHINGTON, D.C., May 11, 1977.

DEAR SENATOR TALMADGE: I have read with interest your remarks in the Congressional Record of May 5, 1977 on introducing S. 1470—the Medicare-Medicaid Reimbursement Reform Act.

I have no doubt that the substance of your legislative proposal is a rational and far-sighted effort to deal with pressing domestic health problems. I am concerned, however, that some of your introductory remarks may be interpreted as critical of the integrity and commitment of the “bureaucrats” who ultimately must turn your proposal into operating reality.

As a taxpayer and an occasional “victim” of the sometimes mindless ways of local, State, Federal and Congressional bureaucrats, I can readily applaud the efforts of President Carter and Secretary Califano to reform and reorganize the Federal Government. But as a career civil servant, I am increasingly apprehensive that present efforts to reorganize may fail if they are based upon the wrong industrial model.

Government organizations in the health and welfare area do not stamp out unique industrial products which are produced by unskilled, interchangeable workers (although the results sometimes seem to indicate the latter). The business of such Government agencies is service, not products.

In your remarks, you expressed concern for the manner in which the new Health Care Financing Administration is organized and staffed. It is of course true, as you have frequently pointed out, that Government organizations with overlapping positions and unclear lines of authority are wasteful and inefficient. I personally do not have sufficient information to know whether the design of the new agency meets your objectives, but I am convinced that creating an organization on paper which avoids these mistakes is less than half the battle. Ultimately, the service performed by these agencies will only be as good as the skills and morale of the “bureaucrats” make them.

It seems to me that the emphasis of your comments focuses on where the staff of the new agency may come from rather than upon their individual competence. This has very negative implications for the morale and effectiveness of the new agency's staff.

In discussing Secretary Califano' recent reorganization in which the Social and Rehabilitation Service (SRS) was eliminated, you refer to SRS as "a large an inefficient welfare bureaucracy". You further state that "a number of high-level bureaucrats whose jobs were eliminated in the welfare area are attempting to scramble into the new health financing agency." The clear implication of these remarks is that these high level employees (and presumably other SRS bureaucrats as well) are unworthy of further consideration or employment.

Bureaucrats, like politicians, have become accustomed to a certain amount of criticism (some of its informed, much of it not) but all of us would like to draw the line some place short of guilt-by-association.

It does not follow, Senator, that because I or any of my co-workers once were employed at the Social and Rehabilitation Service, we are all inefficient and somehow dangerous to any other government organization.

I will not quarrel with your conclusion or the conclusions of others that SRS was inefficient and failed to meet many of its noble objectives. As a part of the organization for 5 years, I have to acknowledge my participation in many of the agency's failings. But I wonder if I shouldn't share some of my disappointment and guilt in SRS's failings with past Secretary's of HEW; with State and local officials; with the White House; the Office of Management and Budget, and with the Congress.

I wonder what we would be saying today about the efficiency and competence of the staff of the Senate Committee on Agriculture or the staff of the Committee on Finance in implementing policy, if they had to work for seven different Chairmen or Acting Chairmen from 1972 to 1977. I wonder how they would have performed if the White House, the Majority Leader and other members of the Leadership constantly intervened to change policy. Further, how effective would they have been if they only worked on the programs which had the least popular support and understanding among the voting public? Yet this is roughly analogous to the atmosphere in which the Social and Rehabilitation Service operated.

I honestly believe it would be hard to find anyplace else in government with as high a percentage of skilled, highly motivated employees. These SRS employees knew they would work on programs which benefit the least politically significant segment of our population, and for which there is little interest, or support among the most important areas of a bureaucrat's Washington "world" *i.e.* The Executive branch; their peers, the Press and the Congress. I agree that if we could simply attribute the failures of SRS to the stupidity and laziness of its employees it would be a lot easier for the average taxpayer to understand but the real tragedy of SRS is not in how bad its employees are—but how good!

In recent years there has been little lustre to public service. It can do no good to new organizations or to former SRS employees to know that our reputations are forever tarnished—not by how little or how much we as individuals did—or by how much we knew—or by how much we tried—but simply because we were part of SRS.

As one of the SRS "displaced bureaucrats," I am not looking for a "haven" somewhere. I don't know anyone who is. What we all are looking forward to is an opportunity to continue to participate in public service and to be judged as individuals with individual strengths and weaknesses.

Hopefully, all of us will have the chance to work somewhere in the Federal Government in a more efficiently organized agency, free from constant turnovers of leadership and policy. Hopefully, if doors are closed on us, it will be because we are not qualified or there is someone better, not because of past association with SRS.

In your long and distinguished career as a public servant, you have frequently shown an appreciation for the efforts of other public employees. I hope you will soon take the opportunity to correct the record with respect to the employees of SRS.

My best wishes for your continued participation and success in public life.

Very truly yours,

RONALD D. SCHWARTZ,

Former Assistant Administrator for Legislation, former Acting Associate Administrator for Policy Control and Coordination.

STATEMENT OF KENNETH T. WESSNER, PRESIDENT AND CHIEF EXECUTIVE OFFICER
OF SERVICEMASTER INDUSTRIES INC.

Mr. Chairman and distinguished members of this subcommittee, I am Kenneth T. Wessner, President and Chief Executive Officer of ServiceMaster Industries Inc.; and I am pleased to testify before you today with respect to S. 1470, the "Medicare-Medicaid Administrative and Reimbursement Reform Act". Having spent some time earlier this year with the distinguished senior Senator from Georgia, I am pleased that he has introduced the legislative package before us today with such an outstanding list of co-sponsors from among his colleagues, and with considerable support from various sectors of the health care field. The support which he has garnered is not only a tribute to the Chairman's prestige, but also reflects admirably on the substantive provisions and concepts embodied in the proposed legislation.

WHAT IS SERVICEMASTER

At the outset of my remarks and prior to any discussion of S. 1470 or the Administration's bill, I would like to make some comments about ServiceMaster and tell you why we are here today. This year marks our company's 30th anniversary as a corporation. During this period of time, ServiceMaster has become the nation's leading supplier of contract housekeeping, laundry and plant operations and maintenance management services to hospitals. Currently, 577 hospitals located in various parts of the country are being served with one or more of our services. Because we are paid by the respective hospitals to provide better services at lower costs than they can otherwise obtain, we have considerable experience with cost containment techniques and we share the Chairman's goals and those of the Administration in seeking to bring hospital costs within reasonable limits.

Approximately 92 percent of our company's net operating revenues are contributed by our Hospital Service Divisions. These Divisions furnish specialized managerial skills, equipment, and cleaning and maintenance chemicals for hospital housekeeping, laundry and maintenance. Generally speaking, the hospitals in question enter into individual contracts with ServiceMaster for a two-year period with provisions for yearly renewals and with a variety of services being offered from which the individual hospitals may select some or all. Most of the hospitals receive housekeeping management services, while approximately 22 percent receive laundry management services and approximately 20 percent are being served by our plant operations and maintenance management programs. In addition, ServiceMaster has two new programs involving clinical equipment maintenance and materials management which are now operative in several hospitals in various parts of the country. While the health care field is demanding increased services, higher degrees of care and the implementation of cost containment techniques, ServiceMaster is meeting these needs and is providing a clean, safe environment for more hospital patients each year.

During the past decade, health care expenditures increased from \$42 billion to an estimated \$142 billion, while hospital expenditures alone rose from \$14 billion to an estimated \$57 billion. As this nation's hospital bill has risen, hospital administrators have turned increasingly to ServiceMaster and others to solve cost problems which have been eroding valuable administrative time and hospital resources alike. In the fields of housekeeping, plant operations and maintenance, clinical equipment maintenance, laundry and linen, and materials management, ServiceMaster has built an enviable record and reputation. At the same time, the people at ServiceMaster have become an integral part of each hospital's team by providing services programmed specifically for the hospital's needs. In this process, we have not looked upon hospitals merely as buildings to be cleaned, but rather as special kinds of institutions to be served where the ultimate customer is the patient.

Housekeeping

When one thinks of housekeeping services today, it is not fair or accurate to think only in terms of clean appearances. It is the thorough cleaning and maintenance of a highly sanitary environment by each of our employees—whether the environment consists of an operating room or the patient's room—that contributes ultimately to helping patients get well. The daily services undertaken

by ServiceMaster are performed principally by hospital employees themselves who are trained and supervised by managers employed by ServiceMaster. For example, in a typical situation, ServiceMaster's resident coordinating manager oversees the complete training, direction and motivation of all housekeeping personnel, plus regular quality assurance inspections with hospital administration personnel. As a result, our company seeks to instill a new sense of teamwork in hospital activities, and a sense of caring and working together to provide a better hospital environment.

Plant operations and maintenance

With respect to the plant operations and maintenance functions undertaken by ServiceMaster, these are vitally important because everyone involved in the health care delivery system of a hospital depends upon uninterrupted services provided by the physical plant, 24 hours a day, year after year. There can be no equipment breakdowns or other failures of this nature if essential and often urgent patient needs are to be met. Within this context, our services encompass the entire environmental system: the heating plant, water requirements, electrical and emergency power and lighting distribution, oxygen supply and distribution, suction, incineration, and all building and grounds equipment. Just last year, ServiceMaster instituted a new program of computerized preventive maintenance which we anticipate will contribute greatly to the goals under discussion.

Clinical equipment maintenance

ServiceMaster's Clinical Equipment Maintenance Program is an integral part of Plant Operations and Maintenance, and includes managing preventive and corrective maintenance of diagnostic and therapeutic equipment, from monitoring equipment in intensive care units, operating rooms and recovery rooms, to laboratory analysis equipment. Indeed, ServiceMaster's professional management services insure maximum operating efficiency and safety for both patients and the equipment operators.

Laundry and linen

The laundry and linen distribution department of a hospital is another time-consuming, but highly important function. It involves everything from patient linen to surgical gowns; and it is in this area that ServiceMaster has been applying a new level of professionalism. The ServiceMaster program includes the collection of all soiled linens, the latest laundering techniques, and the distribution of laundered linens back to the patient and operating rooms and other areas of linen inventory. While these services may not seem to be particularly important at first blush, if you or a member of your family has spent any time in a hospital recently, you will remember how important clean linens were with respect to your attitudes and outlook during the recovery process.

Materials management

Our Materials Management Program involves the purchasing, receipt, storage and movement of all types of materials; and the management of central supply services, perpetual item inventory systems, and the financial accounting of supplies and equipment. Each one of these responsibilities is vitally important to the successful operation of today's modern hospitals.

In 1976 alone, our Materials Management Program and the other programs described above helped provide cleaner, safer hospitals for nearly 5 million hospital patients and more than 18 million outpatients. Because of these and other statistics, ServiceMaster is justifiably proud of its growth and its contribution to this nation's health care program.

WHY ARE WE HERE TODAY?

Having told you what ServiceMaster does, the next question becomes: Why are we here before you today? The simple answer is that we care—we care about the hospitals which we serve; we care about our employees who provide the services discussed above; and we care about our ultimate customers, the patients in these hospitals. We are certainly proud of what we have accomplished in the past, as well as what we are attempting to do in the future. As I stressed

earlier in these remarks, we are concerned about containing hospital costs—a goal which we have been concerned about for the past three decades. Nevertheless, we believe that there are a number of alternative approaches available to achieve this goal, some of which will advance our aims and others which will retard our efforts.

In this regard, it may be useful to lay before you today one company's experience with the issue of hospital cost containment. Late last year, our company completed a study of 188 hospitals which we serve; and we found that the provider's cost had been reduced in two-thirds of them because of our efforts. In the aggregate, the reduction amounted to approximately 7 percent. In three-fourths of the hospitals studied, our average price of services rendered was less than the value of equivalent in-house managed services.

As the table below illustrates, with respect to the hospital selected, housekeeping costs declined considerably after ServiceMaster undertook its responsibilities.

	Aggregate hospital housekeeping costs—		Savings	Percent savings
	Before Service Master	After Service Master		
Hospital A.....	\$2, 398, 930	\$1, 954, 740	\$444, 190	18. 5
Hospital B.....	649, 995	580, 338	69, 657	11. 0
Hospital C.....	153, 286	117, 963	36, 323	23. 5
Hospital D.....	313, 154	230, 206	82, 948	26. 0
Hospital E.....	507, 824	424, 403	83, 421	16. 0

While greater efficiencies may be achieved as a result of these and similar services provided by ServiceMaster and others, there is reason to believe that much of the "fat" has already been rung out of various functions performed by hospitals in various parts of the country; and further cost-cutting efforts may serve only to reduce the quality and quantity of health care services provided to hospital patients. To put it bluntly, a high degree of efficiency has been attained at many of this nation's hospitals; and the application of certain cost containment alternatives being proposed may produce detrimental rather than beneficial effects on these institutions.

THE LEGISLATIVE ALTERNATIVES

After having discussed ServiceMaster's activities in some detail, as well as specific examples of cost reductions which have been achieved, it is useful to discuss the Talmadge bill in very general and conceptual terms, as well as the Administration's proposal. At the outset of these comments, it should be noted that ServiceMaster endorses the goals embodied both in S. 1470 and the Administration bill, as they pertain to cost containment; however, we differ with the means proposed in the latter measure to achieve the desired results. In our opinion, and with all due respect to those within the Administration who drafted the "Hospital Cost Containment Act of 1977," the bill does not give adequate consideration to our national health care system, but deals principally with the issue of hospital cost increases which is only one factor contributing to this nation's rising health care bill.

Simply put, the Administration proposal seeks to eradicate the "illness" without coming to grips with those factors which produced the malady in the first place. It seems to lose sight of the fact that inflationary pressures beyond the control of individual hospitals or their administrators are contributing significantly to the very hospital cost increases which are being criticized. It is respectfully submitted that any effort to single out hospitals as the "villain" in this situation is both unrealistic and unproductive.

We must not lose sight of our national need to provide health care delivery systems which improve health standards and contribute further to the enormous strides which have been made in the field of health over recent years. As pointed out in the American Hospital Association's testimony before the Health Subcommittees of the House, health care expenditures in all Western nations have

been increasing at a rate greater than their gross national products. Since hospitals must pay higher prices for the goods and services which they use in the delivery of patient care, the cost of hospital services is adversely impacted by our inability to control inflation generally. In this regard, I respectfully refer this subcommittee's attention to the AHA's discussion of increases in the Consumer Price Index and other indices, contained in its testimony before the House subcommittees, which bears out the notion that the hospital "market basket" has been hit especially hard by inflation.

During recent years, we have also witnessed an ever growing public demand for health care services stimulated in large part by the increased elimination of economic barriers to the utilization of our health care system. While economic barriers to the use of such services have diminished—a development which in many respects may be healthy—the kinds and volumes of services used by patients are also increasing in intensity because of new technological advances and other factors which lead to inevitable cost consequences. Finally, the notion of increased regulation by the Federal Government and other regulatory bodies cannot be overlooked as a significant factor in escalating costs. While certain benefits have been produced by governmental scrutiny and regulation, there have been far too many examples of compliance with regulations being achieved without a commensurate improvement in the quality of health care provided.

Simply stated, the Administration's bill would provide for a 9 percent cap on increases in hospital in-patient revenues, while it ignores the fact that hospitals must acquire goods and services from other segments of the economy which are uncontrolled and which may be experiencing high rates of inflation. If enacted, efficient hospitals which are already controlling costs might be required to curtail essential services and sacrifice the quality of health care to survive, while inefficient hospitals would be "rewarded" for their laxity. On the other hand, the Chairman's bill, S. 1470, provides incentives for efficient operation and penalties where institutional costs significantly exceed the average for comparable institutions. Without discussing the specific provisions embodied in these two pieces of legislation, it is our considered opinion that the Talmadge bill represents a more reasonable and realistic approach to the problems at hand, while the Administration proposal requires further study and reflection.

Because of the work that our company has done with respect to the containment of hospital costs, we would welcome the opportunity to share other examples of our efforts—and of savings which can be realized realistically in the future—with this subcommittee. Again, it is an honor and a privilege to appear before you today. For the reasons set forth above, we endorse the general approach taken in S. 1470 and urge the enactment of this or similar legislation at an early date. We look forward to the opportunity of working together in the months to come with the distinguished members of this subcommittee and its able staff, and to the fashioning of refinements to the Talmadge bill which may enhance its workability and ultimate effectiveness.

Mr. Chairman, thank you again for giving us this opportunity to testify. We commend you for your leadership in the field of health care delivery systems, and we look forward to making any contributions to your legislative efforts which might advance our common goals and hasten the day when the problems before us will be issues of the past.

STATEMENT OF WILLIS B. GOLDBECK, DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH

INTRODUCTION

The Washington Business Group on Health (WBGH), comprised of 145 member companies (see Appendix) providing the health benefits for some 30,000,000 employees, retirees and dependents, appreciates this opportunity to share its views on this important legislative effort. My name is Willis B. Goldbeck and I am the Group's Director.

Health and medical care costs are of vital concern to our nation's major employers. This is true not only because of the many billions of dollars spent, and the unacceptably high rate of medical cost escalation, but also because most employers are keenly aware of the terrible waste and excess which now pervades our medical care system.

In an era of limited resources, it is no longer enough to be proud that the United States has the most sophisticated medical technology, or the most skilled physicians or even the highest quality of treatment. The challenge we all face is how to retain those features which make our system the envy of the rest of the world while simultaneously controlling the cost of that system. To do this and increase access to that system for those now underserved makes the challenge almost imponderably complex.

Therefore we feel Senator Talmadge, the bill's Co-sponsors and their staff are to be commended for their willingness to accept the challenge. S. 1470 is a valuable contribution to a difficult and emotional debate.

The paramount problem

No matter what other merits S. 1470 may have, it will be totally unacceptable to the Washington Business Group on Health if its application is restricted to the Medicare and Medicaid programs.

The escalating hospital costs are not restricted to public programs in either their cause or effect. We fully appreciate the need to limit the continuing increase in the amount of Medicare/Medicaid expenditures. However, S. 1470 is a valid approach only if it does not result in increased expenditures elsewhere.

We are convinced that every dollar "saved" by this bill, as presently drafted, would be converted to a dollar charged to private payors. Proof of this can be found in the surcharge now applied to private payors to compensate for the low levels of Medicare and Medicaid reimbursement. There is not one iota of evidence that hospitals would voluntarily absorb any losses induced by S. 1470, especially when it would be so easy to simply shift prices to private payors.

The Administration recognized this problem in its bill (S. 1391, The Hospital Cost Containment Act of 1977) and we would reiterate that, unless a method to prevent cost shifting is made a clear part of S. 1470, we respectfully suggest that the bill not be reported from Committee.

Positive aspects of S. 1470

There are several concepts in S. 1470 which are excellent and should be retained in any amended edition of the bill. For example:

1. We endorse the State exemption provision and would recommend that it be used to encourage an increase in State rate review programs with a prospective budget system.

2. Closing and converting hospitals are essential steps if we are serious about cost containment. And, at the local level, nothing is more controversial. You are to be commended for facing this issue and recognizing that transitional financing will be needed.

3. We endorse the uniform reporting requirement, but not uniform functional accounting. The government must make clear what information it needs to determine operating and capital costs for hospital services. This would permit hospitals to modify their accounting systems so as to meet the needs of management while generating the required reports.

In the development of uniform reporting requirements, self-insured employers should be represented.

4. In an effort to provide more realistic cost comparisons, we endorse the concept of classifying hospitals.

5. The provision in Section 41 to assure that ambulance service is directed to the most medically appropriate facility is commendable.

6. We endorse Section 42 which recognizes the value of health education and preventive care programs in the detection and treatment of respiratory diseases. This is the type of increased expenditure which can contribute to meaningful, long-term cost containment.

7. We agree that fringe benefit costs should be included in any wage base formula. This is something that S. 1391, the Administration's bill, fails to do. Fringe benefits should include Social Security taxes. However, we would note that the time has come to recognize that hospital workers are not, generally, underpaid. In fact, many are paid at levels above those of their counterparts in other industries. Therefore, we recommend that any wage pass-through be used selectively to address only those geographical and employment areas where genuine need for catch-up still exists.

8. We endorse your efforts to encourage physicians to locate in underserved areas. However, we must note that a prime disincentive to do so is the fact that Medicaid and Medicare pay on a reimbursement schedule far below that

which is "usual, customary and reasonable." The private payors make up the difference and thus attract the most physicians. More importantly, we feel Congress must soon address the major issue of medical manpower: over abundance and the perverse impact supply has on demand in the medical care marketplace.

Recommendations, comments and questions

1. The revenue controls must be designed to avoid an increase in utilization to compensate for the reduced per diem revenue.

2. Apply the controls to all care, not just in-patient. We, too, favor incentives to increase the use of out-patient care. But, such incentives must be accompanied by controls which preclude shifting expense allocations from in-patient to out-patient categories. That type of shift would defeat the overall cost containment objective and, inflate and distort the cost of out-patient care.

3. We recommend the retention of the Health Insurance Benefits Advisory Committee (HIBAC).

4. We endorse the concept of bonus payments for those institutions whose routine operating costs fall below the group average. However, we seriously question whether it is good policy to fully reimburse a hospital when its actual costs exceed "target rates" by as much as 20%. This overrun percentage is too high to compel management to eliminate wasteful procedures.

5. On the issue of closing hospitals, three major problems need more consideration:

A. How is the value to be determined for proprietary hospitals for which the investments were made for reasons very different than those in the Not-For-Profit class?

B. How does the "buy-out" concept apply to older, fully paid for institutions?

C. Does the "buy-out" concept apply to projects now underway but not yet in their construction phase? We believe it should.

And a word of caution: new facilities, if well designed, can be cost savers and should not automatically be viewed negatively.

6. We recommend that a careful review be established covering the reporting requirements of all health programs such as Planning, HMO, PSRO, State rate review, Medicaid, Medicare, etc. The more the government becomes involved, the more necessary such a review becomes.

7. Nursing homes, hospital leased space, ambulatory care and surgi-centers should all be included in the legislation.

8. While we agree with the objective of encouraging physicians to accept assignment, we question whether the \$1,003 incentive is an adequate inducement. We are also very concerned that the bulk-billing provision appears to be an open-ended invitation to fraud. As written, the bill may cause assignment rates to drop.

9. Section 11, (E) would establish Statewide prevailing charge levels. It is not clear how that would adequately reflect the wide variations between, for example, Chicago and the rest of Illinois.

10. Why should 75% of the current pre-state error rate be acceptable? At least, the bill should provide a phased-in reduction which in three years would bring the rate down to 25%. If left as is, 75% will quickly become the new minimum. Further, it does not seem reasonable to demand the same degree and speed of improvement in all of the states. The worst States should be given the most stringent requirements.

11. Considering the recent HEW study which showed that some \$532 million could be saved by hospitals through energy conservation techniques, it would be appropriate for S. 1470 to explicitly encourage capital expenditures for this purpose.

12. Malpractice expenses should not be excluded from operating costs. First, the major malpractice costs result from so-called "defense medicine": otherwise unnecessary tests and diagnostic procedures. It is impossible for a government program to determine, for every hospital procedure, what was or was not "necessary". Second, if excluded, the hospital loses the economic incentive to help keep their costs under control.

13. Ancillary service costs should not be excluded. For many hospitals, these costs comprise a very significant percentage of daily revenues: a percentage sure to increase rapidly if excluded from the reimbursement controls.

14. All reporting which have a bearing on hospitals' certification-of-need should be directed to go the Secretary of HEW through the local Health Systems Agency.

CONCLUSION

For the many elements of S. 1470 to be implemented, it will be necessary to have, in place, an effective health planning system. Currently, the HSAs are not sufficiently funded or staffed to do all that is required. Nor, in our view, is P.L. 93-641 strong enough. The following suggestions are steps we feel would need to be taken to provide a planning process of sufficient magnitude and strength to support the objectives of S. 1470.

1. A recertification process, coupled with strong public disclosure requirements.
 2. Decertification and reassignment of function is needed.
 3. The certificate-of-need procedure should include all medical and health facilities (home health, ambulatory care, corporate extended care clinics, leased space, site and facilities acquisition, and all government beds and facilities).
 4. Large capital expenditures for equipment should also be subject to certification, no matter where that equipment is to be located.
 5. For the planning process to work, a major effort must be directed at establishing scientifically valid and publicly accepted measures of health and medical outcomes, cost-benefit relationships and medical-hospital standards of risk and efficiency.
 6. Credit should be given, during the certification process, for those applications which contain a commitment to nutrition, immunization, hypertension treatment and other health education and life-style improvement objectives.
 7. The mandatory consumer majority should be retained. But doing so involves a commitment to the time and resources necessary to help educate those who have had little or no prior contact with the health system.
 8. The national health policy formulation, called for by P.L. 93-641, must get underway with full participation by all sectors.
 9. A process of medical technology assessment must be established. Its product should be made available to all health planners and its process made an ongoing part of medical education. This must be designed to control access to the marketplace without inhibiting innovation and investment in research.
- With the preceding suggestions and comments, we hope we have made a small contribution to the objective we all share: reduced medical care cost escalation without sacrificing quality care or access to needed services.

APPENDIX

THE WASHINGTON BUSINESS GROUP ON HEALTH

AMAX	Cities Service
AMF	Clark Equipment
ASARCO	Coca-Cola
Aetna	Columbia Gas
Allis Chalmers	Connecticut General
Alcoa	Continental Bank
American Can	Continental Group
American Cyanamid	Continental Oil
American Medical International	Coopers & Lybrand
A. T. & T.	Corning Glass Works
Armco Steel	Deere & Co.
Armstrong Cork	Deering Milliken
Atlantic Richfield	Dow Chemical USA
Babcock & Wilcox	Dresser
Becton, Dickinson & Co.	E. I. duPont
Bethlehem Steel	Eastman Kodak
Boeing	Eaton
Boise Cascade	Eli Lilly
Bristol Myers	Equitable
George B. Buck	Esmark
Budd	Exxon
Burlington Industries	FMC
Burlington Northern	Federated Department Stores
Campbell Soup	Firestone
Carter Hawley Hale	Ford
Caterpillar Tractor	General Electric
Chrysler	General Foods
Citibank	General Mills

APPENDIX—Continued

THE WASHINGTON BUSINESS GROUP ON HEALTH—Continued

General Motors	Philip Morris
GTE	Pitney Bowes
General Tire & Rubber	Proctor & Gamble
GENESCO	Prudential
Georgia-Pacific	Pullman
B. F. Goodrich	RCA
Goodyear	R. J. Reynolds Industries
Greyhound	Ralston Purina
Gulf Oil	Republic Steel
Hanna Mining	Reynolds Metals
Harris Trust & Savings	Rockwell International
Heinz, USA	SCM
C. T. Hellmuth & Associates	St. Regis Paper
Hercules	Scott Paper
Honeywell	Sears, Roebuck
Inland Steel	Shell Oil
Inmont Corp.	Sherwin-Williams
IBM	Singer
International Harvester	A. O. Smith
Jewel Companies	SmithKline
John Hancock	Southern California Edison
Johns-Manville	Sperry Rand
Jones & Laughlin Steel	Standard Oil of California
Kaiser	Standard Oil (Indiana)
Kennecott Copper	Stanley Works
Koppers	Stauffer Chemical
LTV	Sun Co.
Libbey-Owens-Ford	Sundstrand Chemical
3M	TRW
Marathon Oil	Tenneco
Marcor	Texaco
Martin Marietta	Texas Gas Transmission
Mead	Texas Instruments
Merck	Travelers
Metropolitan Life	Union Camp
Mobile Oil	Union Carbide
Monsanto	Union Electric
National Steel	Union Pacific
Northern Natural Gas	Uniroyal
Olin	U.S. Steel
Owens-Corning Fiberglas	Westinghouse Electric
Owens-Illinois	Weyerhaeuser
PPG Industries	Whirlpool
Pet	Xerox
Pfizer	

APPENDIX B

HEALTH CARE EXPENDITURES AND THEIR CONTROL—BY THE HEALTH
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HEALTH CARE EXPENDITURES AND
THEIR CONTROL

THE HEALTH STAFF
Education and Public Welfare Division

May 25, 1977

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HEALTH CARE EXPENDITURES AND THEIR CONTROL

ABSTRACT

This paper examines the issue of rising health care expenditures, an issue of current concern as Congress examines proposals to control hospital costs, proposals to improve the administration and control the escalating costs of the Medicare and Medicaid programs, and national health insurance proposals. Four major aspects of this issue are described in this paper; the fifth section deals with questions for analyzing any health expenditure control proposal:

I. This section includes various data on rising health expenditures including national health expenditures, personal health care expenditures, sources of payment for health care, and measures of price and cost increases for health care.

II. The reasons why health care expenditures are an issue are explored, such as their impact on public expenditures, industry expenditures, and expenditures by the consumer through direct payments, insurance premiums, taxes, foregone wage increases, and an increased cost of living.

III. The many factors contributing to rising health care expenditures are examined, such as increased health resources, third-party coverage, and reimbursement methods.

IV. Many of the attempts, proposals, and theories to control rising health care expenditures are described, such as the Economic Stabilization Program, health facility planning, and efforts to limit reimbursements to providers.

V. Several questions which should be asked when examining a proposal to control health expenditures are given.

HEALTH CARE EXPENDITURES AND THEIR CONTROL

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HEALTH CARE EXPENDITURES AND THEIR CONTROL

INTRODUCTION

The soaring expenditures for health services have become an increasingly important policy issue, especially over the past 10 years. As the nation's leading health care purchaser, the issue is of particular importance to the Federal Government. Between 1965 and 1976, the percentage of health expenditures funded through Federal, State, and local sources has risen from 24.5 percent to 42.2 percent.

This report analyzes the increases in health care expenditures that have taken place and the major factors that have produced them. Following this background on the nature of inflation in the health care segment of the economy, the report discusses the various measures that have been proposed or attempted in an effort to contain it.

I. BACKGROUND DATA

A. National Health Expenditures

National health expenditures have increased for nearly 50 years in aggregate terms, on a per capita basis, and as a percent of the Gross National Product (GNP). These expenditures, which include all public and private spending for health care services, medical facility construction, research, and other health expenditures, amounted to \$3.6 billion in FY 1929, which was approximately \$29 per capita and 3.5 percent of the GNP. By FY 1976, expenditures totalled \$139.3 billion, nearly \$638 per capita and 8.6 percent of the GNP. The growth in national health expenditures is shown in the following table.

AGGREGATE AND PER CAPITA NATIONAL HEALTH EXPENDITURES, AND
PERCENT OF GROSS NATIONAL PRODUCT, SELECTED
FISCAL YEARS, 1929-1976

Fiscal Year	Total (in millions)	Health Expenditures	
		Per Capita	Percent of GNP
1929	\$ 3,589	\$ 29.16	3.5
1940	3,883	28.98	4.1
1950	12,027	78.35	4.5
1960	25,856	141.63	5.2
1965	38,892	197.75	5.9
1970	69,201	333.57	7.2
1971	77,162	368.25	7.6
1972	86,687	409.71	7.8
1973	95,383	447.31	7.7
1974	106,321	495.01	7.8
1975	122,231	564.35	8.4
1976 <u>1/</u>	139,312	637.97	8.6

1/ Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

The rate of growth in national health expenditures has averaged 8.1 percent per year from FY 1929-FY 1976. In the 1930's, the decade of the great depression, expenditures grew at an annual rate of less than one percent, but in the 1940's, expenditures increased by an average of 12 percent per year. The average annual increase in

the 1950's and early 1960's dropped to approximately 8 percent per year. Since FY 1965, the last year before the enactment of Medicare and Medicaid, expenditures have increased at a rate greater than 12 percent per year. In the last two years, the annual growth has been higher. Expenditures increased by 15 percent in FY 1975 and 14 percent in FY 1976. The following table presents the data:

AVERAGE ANNUAL INCREASE, NATIONAL HEALTH EXPENDITURES,
SELECTED FISCAL YEARS FROM 1929-1976

<u>Fiscal Years</u>	<u>Average Annual Percentage Increase</u>
FY 1929-FY 1976	8.1
FY 1929-FY 1940	0.7
FY 1940-FY 1950	12.0
FY 1950-FY 1960	8.0
FY 1960-FY 1965	8.5
FY 1965-FY 1970	12.2
FY 1970-FY 1976	12.6
FY 1970-FY 1971	11.5
FY 1971-FY 1972	12.3
FY 1972-FY 1973	10.0
FY 1973-FY 1974	11.5
FY 1974-FY 1975	15.0
FY 1975-FY 1976 <u>1/</u>	14.0

1/ Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

B. National Health Expenditures, by Type of Service

Expenditures for hospital care and nursing home care have accounted for a consistently increasing proportion of national health expenditures. As shown in the following table, hospital care expenditures have increased from 18.1 percent of total expenditures in FY 1929 to 33.8 percent in FY 1965 and 39.8 percent in FY 1976. Nursing home care expenditures have increased from less than one percent of the total in FY 1940 to 3.3 percent in FY 1965 and 7.6 percent in FY 1976.

CRS-3

NATIONAL HEALTH EXPENDITURES BY TYPE OF EXPENDITURE, AMOUNTS AND PERCENT
DISTRIBUTION, SELECTED FISCAL YEARS, 1929-1976

Fiscal Years	Aggregate Amounts (in millions)					Other Health Services and Supplies 1/			
	Total	Hospital Care	Physicians' Services	Dentists' Services	Drugs and Drug Sundries	Nursing Home Care	Research and Medical Facilities Construction		
1929	\$ 3,589	\$ 651	\$ 994	\$ 476	\$ 601	2/	\$ 650	\$ 207	
1940	3,883	969	946	402	621	28	763	134	
1950	12,027	3,698	2,689	940	1,642	178	2,034	847	
1960	25,856	8,499	5,580	1,944	3,591	480	4,068	1,694	
1965	38,892	13,152	8,405	2,728	4,647	1,271	5,461	3,228	
1970	69,201	25,879	13,443	4,473	7,114	3,818	9,338	5,137	
1975	122,231	48,224	22,925	7,810	10,269	9,100	16,324	7,579	
1976 3/	139,312	55,400	26,350	8,600	11,168	10,600	18,904	8,290	
Percentage Distribution									
1929	100.0	18.1	27.7	13.3	16.7	2/	18.1	5.8	
1940	100.0	25.0	24.4	10.4	16.0	0.7	19.6	3.5	
1950	100.0	30.7	22.4	7.8	13.7	1.5	16.9	7.0	
1960	100.0	32.9	21.6	7.5	13.9	1.9	15.7	6.6	
1965	100.0	33.8	21.6	7.0	11.9	3.3	14.0	8.3	
1970	100.0	37.4	19.4	6.5	10.3	5.5	13.5	7.4	
1975	100.0	39.5	18.8	6.4	8.4	7.4	13.4	6.2	
1976 3/	100.0	39.8	18.9	6.2	8.0	7.6	13.6	6.0	

Note: Rows may not add to totals due to rounding.

1/ Includes other professional services, eyeglasses and appliances, expenses for prepayment and administration, government public health activities, and other health services.

2/ Not available.

3/ Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

C. Personal Health Care Expenditures, by Source of Payment

Personal health care expenditures reflect the nation's expenditures for the care of individuals, and exclude spending for research, construction, government public health activities, and expenses for prepayment and administration. Expenditures for personal health care services come from a variety of sources, with the principal ones being direct payments by the patient (so called "out-of-pocket" payments), private insurance benefits, and public programs.

In aggregate terms, payments from all of these sources have steadily increased. However, the relative contribution of each of these sources of payment has shifted over the past decades. The portion made by direct payments has steadily declined for nearly 50 years, dropping from more than 88 percent in FY 1929 to 52 percent in FY 1965 and 32 percent in FY 1976. This decline has been caused by increases in payments from two other sources--insurance benefits and public programs. The most dramatic growth in insurance benefits was during the 1950's and early 1960's. Public programs assumed a rapidly increasing share of personal health care payments after the enactment of Medicare and Medicaid in 1965. The following table presents the data on a historical basis.

CRS-5

11/ Direct payments include any insurance benefits.
2/ Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

D. Sources of Increase in Personal Health Care Expenditures

These increases in aggregate health expenditures are caused by a number of factors. The Social Security Administration has summarized the three components of the increased spending as follows:

- changes in the prices of medical services and goods;
- changes in the size and age distribution of the population; and
- changes in the composition of the services and goods provided, including changes in utilization.

They have estimated that the \$110 billion increase in personal health care expenditures from FY 1950-FY 1976 can be broken down among the factors as follows: price increases, 54.6 percent; population change, 10.5 percent; and changes in the quantity and character of the health care patients receive, 34.9 percent. However, the relative influence of the factors has changed during different parts of that time period, as the following table demonstrates.

PERCENTAGE DISTRIBUTION OF SOURCES OF INCREASE IN PERSONAL
HEALTH CARE EXPENDITURES, FY 1950-FY 1976

	<u>Total Increase</u>	<u>Price</u>	<u>Population</u>	<u>Changes in Quantity and Character of Health Care</u>
1950-1976	100.0	54.6	10.5	34.9
1950-1965	100.0	43.8	21.0	35.2
1965-1971	100.0	49.9	8.9	41.2
1971-1974	100.0	43.1	7.9	49.0
1974-1976	100.0	78.3	5.7	15.9

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

E. Price and Cost Increases

Increases in the price of health care, as measured by the Consumer Price Index, have consistently exceeded price increases in the rest of the economy for decades. The only exception to this trend was during the Economic Stabilization Program, when medical care prices increased at lower rates than general price levels. Since these controls were lifted, medical care prices have again increased faster than all consumer prices. The following table summarizes the average annual increases in various components of the Consumer Price Index for FY 1960-1966 (pre-Medicare and pre-Medicaid), FY 1966-1971 (post-Medicare and post-Medicaid), the Economic Stabilization Program, and the post controls period.

ANNUAL RATES OF CHANGE IN CONSUMER PRICE INDEX
AND SELECTED MEDICAL CARE COMPONENTS,
SELECTED PERIODS, 1960-1976

	Fiscal 1960-66	Fiscal 1966-71	Economic Stabilization Program 8/71-4/74	Post Controls Period 4/74-12/76
CPI, All Items	1.4	4.5	6.4	7.5
CPI, All Services	2.2	6.0	5.1	8.9
Medical Care, Total	2.6	6.5	4.3	11.0
Medical Care Services	3.2	7.7	4.9	11.6
Hospital Service Charge	NA	NA	4.6 ^{1/}	13.4
Semi-Private Room Charge	6.0	14.6	5.7	15.4
Physicians' Fees	2.9	6.9	4.0	11.6
Dentists' Fees	2.3	5.7	4.2	8.6
Drugs and Prescriptions	-0.7	0.9	0.7	7.0

^{1/} Annualized rate of change computed from January, 1972, rather than August, 1971.

Source: Social Security Administration.

Another indication of the increasing cost of health care is the cost data compiled by the American Hospital Association (AHA).

The AHA measures of average expense per patient day and per admission are derived by dividing total hospital expenses by the number of days of care or the number of admissions. Adjustments are then made to account for the volume of outpatient care provided, yielding measures of expense per adjusted patient day and expense per adjusted admission. A summary of these measures since 1965 is as follows.

COMMUNITY HOSPITAL EXPENSE PER ADJUSTED PATIENT DAY
AND PER ADJUSTED ADMISSION, 1965-1975

	Expense Per Adjusted Patient Day		Expense Per Adjusted Admission	
	<u>Amount</u>	<u>Annual Percentage Increase</u>	<u>Amount</u>	<u>Annual Percentage Increase</u>
1965	\$ 40.56	—	\$ 310.79	—
1966	43.66	7.6	337.54	8.6
1967	49.46	13.3	409.04	21.2
1968	55.80	12.8	471.30	15.2
1969	64.26	15.2	539.25	14.4
1970	73.73	14.7	610.10	13.1
1971	83.43	13.2	675.01	10.6
1972	94.87	13.7	749.47	11.0
1973	102.44	8.0	799.03	6.6
1974	113.55	10.8	885.69	10.8
1975	133.81	17.8	1,026.79	15.9

Source: American Hospital Association, Hospital Statistics, 1976 Edition.

II. WHY ARE HEALTH CARE EXPENDITURES AN ISSUE?

The increasing expenditures, prices, and costs of health care have become a major issue facing the Congress for a variety of very practical reasons. The increases have had a large impact on:

- public expenditures by Federal, State, and local governments;
- industry expenditures for employee-benefit plans; and
- ultimately, consumer expenditures, through direct payments for health services; insurance premiums; taxes; foregone wage increases in favor of increased health insurance fringe benefits; and an increased cost of living due to the impact of health spending on the rest of the economy.

In addition, the increases remain an issue because it is unclear exactly what the expenditures are buying in terms of the standard of health in the United States.

A. Public Expenditures

The portion of national health expenditures financed from public sources (Federal, State, and local governments) has grown much more rapidly than expenditures from private sources. The public share increased from 13.3 percent of total spending in FY 1929 to approximately 25 percent in FY 1950, and remained about 25 percent of total spending through FY 1965. Since FY 1965, the public share has steadily increased, so that in FY 1976, public spending accounted for 42 percent of total national health expenditures. The following table summarizes the growth in public expenditures for health care.

PUBLIC SHARE OF NATIONAL HEALTH EXPENDITURES, SELECTED
FISCAL YEARS, 1929-1976 (IN MILLIONS)

Fiscal Year	National Health Expenditures	Public Expenditures	Public Expenditures as a % of Total
1929	\$ 3,589	\$ 477	13.3
1940	3,883	782	20.1
1950	12,027	3,065	25.5
1960	25,856	6,395	24.7
1965	38,892	9,535	24.5
1970	69,201	25,391	36.7
1975	122,231	50,870	41.6
1976 ^{1/}	139,312	58,820	42.2

^{1/} Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Volume 40, No. 4, April, 1977.

The increasing public expenditures for health care are reflected in the increasing portion of the Federal budget allocated to health programs over the past decade. The health function of the Federal budget, which includes most major Federal health programs except for Defense Department and Veterans' Administration medical care programs, has grown from 2 percent of total Federal outlays in FY 1966 to 9.7 percent of President Carter's budget proposal for FY 1978. The table which follows traces this growth in Federal health spending.

TOTAL FEDERAL OUTLAYS AND FEDERAL HEALTH OUTLAYS,
FY 1966-FY 1978 (IN MILLIONS OF DOLLARS)

<u>Fiscal Year</u>	<u>Total Federal Outlays</u>	<u>Health Function Outlays</u>	<u>Health Function as a % of Total Outlays</u>
1966	\$134,652	\$ 2,638	2.0
1970	196,588	13,051	6.6
1975	326,105	27,647	8.5
1976	366,466	33,448	9.1
1977	417,417	39,505	9.5
1978 <u>1/</u>	459,375	44,485	9.7

1/ Proposed budget.

Source: Office of Management and Budget. Fiscal Year 1978 Budget Revisions, February, 1977.

The major components of public spending for health care are the Medicare and Medicaid programs. In FY 1976, these two programs accounted for a total of \$33.1 billion, or 62 percent of public expenditures for health care.

These rising public expenditures focus increasing attention on health care as policy makers at Federal, State, and local levels must decide how to allocate the limited budgetary resources available to them. Constant trade-offs must be made between health care, social welfare, defense, spending for other governmental programs, and tax reduction. The increased spending for health care reduces the funds available for these other purposes. Attention centers on the cost of health care because the price and cost increases for health care have exceeded those for the general economy, and because cost constraints represent a method of limiting spending without limiting coverage and benefit levels under programs such as Medicare and Medicaid.

B. Employer-Employee Expenditures

Expenditures for health care have been a major source of increases in spending under employee-benefit plans. Employer-employee contributions for health benefits plans reached \$23.1 billion in 1974, or 3.11 percent of all wages and salaries. In contrast, health benefits contributions constituted 2.15 percent of wages and salaries in 1965, and less than one percent in the early 1950's. The following table portrays the growth in contributions under employee benefits plans for health benefits as a percentage of all wages and salaries since 1950.

EMPLOYER-EMPLOYEE CONTRIBUTIONS FOR HEALTH BENEFITS AS A PERCENTAGE OF ALL WAGES AND SALARIES

<u>Year</u>	<u>Health Benefits Contributors as a % of all Wages and Salaries</u>
1950	0.61
1960	1.63
1965	2.15
1970	2.64
1971	2.80
1972	2.98
1973	3.02
1974	3.11

Source: Skolnik, Alfred M. "Twenty-Five Years of Employee-Benefit Plans." Social Security Bulletin, Vol. 39, No. 9, September, 1976.

These contributions finance health benefits protection for employees and their families. A total of 58 million workers were covered for hospitalization, 56 million for surgical benefits, 55 million for medical benefits, and 28 million for major medical benefits.

The growth in contributions has far surpassed the growth in the number of workers covered under health benefits plans, especially in recent years. This reflects both increases in the scope of coverage and increases in the cost of health care. For example, while the number of workers covered for hospitalization increased at an average annual rate of 1.6 percent from 1970-1974, the contributions for hospitalization increased at a rate of 10.9 percent per year. The following table compares increases in covered employees with increases in contributions for health benefits protection.

AVERAGE ANNUAL INCREASE IN COVERED EMPLOYEES AND
IN EMPLOYER-EMPLOYEE CONTRIBUTIONS, 1950-1974

	Average Annual Increases			
	1950-1960	1960-1965	1965-1970	1970-1974
<u>Hospitalization</u>				
Covered Employees	4.9	3.1	3.0	1.6
Contributions	16.1	11.6	11.8	10.9
<u>Surgical--Regular Medical</u>				
Covered Employees				
Surgical	7.8	3.0	3.5	2.2
Regular Medical	13.1	6.3	4.7	3.4
Contributions, Total	14.3	10.5	13.6	15.1
<u>Major Medical</u>				
Covered Employees	NA	13.5	8.2	3.5
Contributions	NA	18.1	16.5	18.9

Source: Skolnik, Alfred M. "Twenty-Five Years of Employee-Benefit Plans." Social Security Bulletin, Vol. 39, No. 9, September, 1976.

These increasing contributions for health benefits protection have focused the attention of employer and employee groups on health care costs. The President's Council on Wage and Price Stability summarized testimony from numerous companies and unions in their recent report, "The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit it Together?" Eastern Airlines reported an increase in health insurance costs from \$430 per employee in 1973 to \$850 per employee in 1976, a period of only minor changes in the benefit package. Bethlehem Steel reported that health benefits costs increased from \$371 per employee in 1970 to \$1,069 in 1976. General Motors reported total health insurance costs of \$825 million in 1976. The size of General Motors' expenditure was highlighted as it was pointed out that health insurance was a larger component of the cost of building an automobile than steel.

Unions are also becoming increasingly concerned at the rising expenditures. The annual increases for health benefits protection force consideration of benefit reductions in some cases, and reduce the amount of money available for wage increases when unions negotiate for their members.

In addition to the direct impact on employers and employees, these increasing health care expenditures fuel inflation in the rest of the economy as the costs of the products produced must be increased to account for the higher expenditures under employee-benefit plans.

C. Consumer Expenditures

All of the spending for health care eventually comes from individuals, whether it is in the form of taxes, insurance premiums, or direct expenditures on health care. The following table displays national health expenditures per capita through these various sources in FY 1976.

PER CAPITA NATIONAL HEALTH EXPENDITURES, BY SOURCE OF FUNDS, FY 1976

Private		
Direct Payments	\$179.05	
Private Health Insurance	167.26	
Other*	22.30	
Total		\$368.61
Public		
Federal	\$182.55	
State and Local	86.81	
Total		<u>\$269.36</u>
TOTAL		\$637.97

*Includes philanthropic spending and industrial in-plant health services.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

An increasing portion of personal income in the United States is being spent on personal health care services. As the following table shows, in FY 1976 approximately 9.2 percent of personal income was spent on personal health care service, compared with 6.5 percent in FY 1965.

PERSONAL HEALTH CARE EXPENDITURES AND PERSONAL INCOME,
SELECTED FISCAL YEARS, 1950-1976

<u>Fiscal Year</u>	<u>Personal Income (in billions)</u>	<u>Personal Health Care Expenditures (in billions)</u>	<u>Personal Health Care Expenditures as a % of Personal Income</u>
1950	\$ 212.2	\$ 10.4	4.9
1960	391.8	22.7	5.8
1965	514.4	33.5	6.5
1970	775.7	60.1	7.7
1975	1,200.0	105.7	8.8
1976	1,314.6	120.4	9.2

Source: Department of Commerce, Bureau of Economic Analysis; and Social Security Administration.

In short, people are spending more on health care than ever before:

- They are spending more through taxes for public programs;
- They are spending more on health insurance premiums;
- They are spending more on direct health care expenditures;
- They are foregoing some wage increases because the costs of health insurance fringe benefits are increasing; and
- They are paying more for goods and services as health expenditures affect the costs of production.

III. WHY HAVE EXPENDITURES FOR HEALTH CARE INCREASED?

A number of interrelated factors have contributed to the increasing costs of health care. It is thus difficult to assess their relative impact.

A. Price Increases

One cause of increasing expenditures is an increase in unit price. This is difficult to quantify in the health care field because the character of the products, or services, does not remain constant. The content of a physician visit or day of hospital care changes significantly over time. For example, the increase in the charges for a day of hospital care from 1965 to 1975 would reflect not only a change in the price for essentially the same services as were provided in 1965 but also the charges added on to pay for increases in staff and in technology. In other words, part of the increase is essentially a matter of paying a higher price for the same thing and part of the increase is for a new, higher level of services.

The Social Security Administration estimates that price alone accounted for approximately 55 percent of the growth in personal health care expenditures from FY 1950-FY 1976. The balance is accounted for by changes in population, changes in the kinds of services provided, and changes in use rates. The relative contribution of price increases has varied during this time period, increasing after 1965, declining during the Economic Stabilization Program, and jumping dramatically following the expiration of controls, as the following table indicates.

PERCENTAGE OF TOTAL INCREASE IN PERSONAL HEALTH CARE
EXPENDITURES ATTRIBUTABLE TO PRICE INCREASES,
SELECTED PERIODS, FY 1950-FY 1976

<u>Fiscal Year</u>	<u>Percentage of Increase Due to Price</u>
1950-1976	54.6
1950-1965	43.8
1965-1971	49.9
1971-1974	43.1
1974-1976	78.3

It should be noted that these estimates, while the best available, may tend to overstate somewhat the portion of the personal health care spending increase which is due to price. The data are derived in part from the CPI medical care price indices, which can reflect to some degree increases due to improvements and/or increases in the services provided.

A recent staff report of the President's Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs," by Feldstein and Taylor, provides a method for determining the component of increasing hospital expenses per day which can be attributed to increasing prices paid by hospitals, as distinguished from the increase which is due to other factors. The study estimated that the average annual increase in hospital expense per patient day of 9.9 percent from 1955 to 1975 could be broken down into its component price and input factors as follows:

-- price factors, total	5.2%
-- earnings per employee	3.6
-- price of non-labor inputs	1.6
-- input factors, total	4.7
-- number of employees	1.5
-- volume of non-labor inputs	3.2
-- total increase	9.9%

The price factors were estimated to account for about one-half (52.6 percent) of the increasing hospital expense per day from 1955-1975. The remaining half of the increase can be attributed to increasing numbers of employees and increasing amounts of non-labor inputs.

Corresponding estimates of the component parts of the average annual increase in expense per day for selected periods from 1955-1975 are presented below.

ESTIMATED COMPONENTS OF INCREASED HOSPITAL COST PER PATIENT DAY, SELECTED PERIODS, 1955-1975

Average Cost Per Patient Day--Average Annual Increases	Components of overall percentage increase in average cost per patient day												
	1955- 1975	1955- 1966	1966- 1975	1955- 1960	1960- 1965	1965- 1970	1966- 1970	1970- 1971	1971- 1972	1972- 1973	1973- 1974	1974- 1975	1/ 18.3
	9.9	6.9	13.6	6.9	6.9	13.3	15.7	13.9	14.0	9.0	11.6	18.3	
Input Factors	4.7	3.4	6.1	3.1	3.7	5.6	7.5	6.0	8.3	3.2	3.7	7.9	
FTE Employees Per Patient Day	1.5	1.4	1.6	1.4	1.5	1.5	2.4	1.9	1.6	1.1	1.8	2.3	
Volume of Non-Labor Inputs	3.2	2.0	4.5	1.7	2.2	4.1	5.1	4.1	6.7	2.1	1.9	5.6	
Price Factors	5.2	3.5	7.6	3.8	3.2	7.7	8.2	7.9	5.7	5.8	8.0	10.5	
Earnings Per Em- ployee	3.6	2.8	4.9	3.0	2.6	6.0	5.7	6.1	4.3	3.0	2.9	6.1	
Price, Non-Labor (CPI)	1.6	0.7	2.7	0.8	0.6	1.7	2.5	1.8	1.4	2.8	5.1	4.4	

Percentage distribution of components of overall increases

Average Cost Per Patient Day--Total Increases	Percentage distribution of components of overall increases												
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Input Factors	47.5	49.3	44.5	44.9	53.6	42.1	47.8	43.2	59.3	35.5	31.6	42.9	
FTE Employees Per Patient Day	15.2	20.3	11.7	20.3	21.7	11.3	15.3	13.7	11.4	12.2	15.4	12.5	
Volume of Non-Labor Inputs	32.3	29.0	32.8	24.6	31.9	30.8	32.5	29.5	47.9	23.3	16.2	30.4	
Price Factors	52.6	50.7	55.5	55.1	46.4	57.9	52.2	56.8	40.7	64.4	68.4	57.1	
Earnings Per Em- ployee	36.4	40.6	35.8	43.5	37.7	45.1	36.3	43.9	30.7	33.3	24.8	33.2	
Price, Non-Labor	16.2	10.1	19.7	11.6	8.7	12.8	15.9	12.9	10.0	31.1	43.6	23.9	

1/ May not add to total due to rounding.

Source: Data derived from Feldstein, Martin, and Taylor, Amy. "The Rapid Rise of Hospital Costs." Council on Wage and Price Stability, Staff Report, January, 1977.

B. Increased Health Resources

Another factor contributing to high health care costs has been the increase in health resources including (1) research, (2) manpower, (3) hospitals, and (4) services and equipment. This increase is due to a number of factors, including: government programs which support resource development, public demand, physician demand, and technological advances. It is thought by some that we now have, or will have in the near future, too much capacity to produce the level of services actually needed. There is also a growing conviction that the creation of service capacity contributes to greater utilization of health services, and that serious consideration must be given to influencing the supply of health resources if we are to effectively limit unnecessary utilization. A major dilemma in establishing policies and programs relative to controlling utilization is the considerable controversy which surrounds the issue of what is a desirable level and mix of health services and what constitutes unnecessary utilization. It is pointed out that it is virtually impossible to limit the use of health services by applying medical criteria alone; costs as well as medical benefits must be taken into account.

1. Research. World War II demonstrated the significance of science, research, and technology in solving problems which had previously been considered beyond solution or understanding. This realization, together with a number of significant breakthroughs accomplished by military medicine, suggested that science and technology could be fruitfully applied to certain chronic diseases and illnesses whose causes and cures were unknown. If sufficient resources could be devoted to expanding the biomedical knowledge base through intensive research, these diseases could perhaps be eliminated or at least significantly reduced in incidence.

There did not exist at that time a large-scale, coordinated research effort to expand in a systematic way the nation's medical knowledge base. The large level of support anticipated to be necessary for an intensive and comprehensive research effort suggested that the Federal Government assume direct responsibility for this effort. This led to a dramatic expansion of the National Institute of Health. In the years following the war, the National Institute became the National Institutes of Health, with a number of additional institutes established, each designed to coordinate and centralize research efforts on one or a group of related diseases. Federal appropriations for these activities have increased substantially--from \$3 million in 1946 to over \$2 billion in 1976.

2. Manpower. Funds for the National Institutes of Health (NIH) were allocated not only for research activities but for training as well. NIH funds provided significant support to medical schools for the development of clinical scientists and medical specialists with broad diagnostic and therapeutic skills. This assistance continued to be the major source of Federal support for health professions training until the early 1960's when perceived shortages of health professionals seemed to demand

an expanded and explicit Federal authority to provide institutional and student assistance for health manpower training.

In order to alleviate some of the problems surrounding the shortages of health manpower, Congress enacted the Health Professions Educational Assistance Act of 1963, which was extended and broadened in 1965, 1968, and 1971. The programs authorized under this legislation were specifically designed to: (1) increase aggregate supplies of health manpower, mainly by increasing enrollments and graduates at health professions schools; (2) provide a stable base of revenue to the educational institutions in order to insure their financial viability; and (3) encourage specific developments at the individual institutions including curriculum improvements, more intensive efforts to recruit minorities, and experiments to train new kinds of personnel such as physician extenders.

Most agree that the Health Professions Educational Assistance Act has been relatively successful in addressing these perceived needs. For example, enrollments in medical schools increased from about 9,000 in 1963-64 to over 14,000 in 1973-74. They are expected to increase to nearly 16,000 by academic year 1979-80. During the decade from 1963-64 to 1973-74, graduations from medical schools increased from 7,300 to 11,600. Corresponding to these substantial increases in manpower were increasing Federal funds devoted to health manpower training programs. Health manpower programs in the Department of Health, Education, and Welfare have grown to appropriations of \$429 million for fiscal year 1976.

Contrary to the usual expectations of the impact of increased supply on cost, studies indicate that the increasing supply of physicians, rather than reducing the cost of medical care, has caused increases in costs because of greater utilization of health services. This is due in part to the fact that, to a considerable extent, physicians can determine the demand for their own services since they not only treat their patients but also determine what services are to be provided.

3. Hospitals. Increased technology and science in medicine demanded a more sophisticated setting for its application. The Hill-Burton program of hospital construction and modernization grants was initiated in 1946 to provide funds for an updated and sophisticated hospital plant which had grown obsolete and inadequate during the depression and war years. From 1942 to 1973 Hill-Burton authority provided \$4.3 billion for 11,255 construction projects, including 5,986 general hospitals with 358,000 beds; 1,795 long-term care facilities with 100,000 beds; and 4,000 mental hospitals, tuberculosis hospitals, outpatient facilities, rehabilitation centers, public health facilities, and State health laboratories.

Approximately 80 percent of the hospitals in the United States are community hospitals, which include non-Federal short-term

general and special hospitals. The number of community hospitals increased little from 1965 to 1975--from 5,736 to 5,875. However, the number of beds in these hospitals increased from 741,000 to 942,000, an increase of 27 percent. The percentage of these beds that are occupied on an average day is 75 percent. This indicates that at any point in time there will be unused hospital beds which cost annually an estimated \$18,000 to \$19,000 per bed, or about half the cost of an occupied bed. It has been estimated that existing hospital capacity could be reduced from 10 to 20 percent without jeopardizing the health of the American people. These unoccupied, and often surplus, beds have contributed to rising hospital costs. Total expenses have increased for all U.S. hospitals from \$36 billion in 1973 to \$49 billion in 1975 (+34 percent) and for community hospitals, from \$28 billion to \$39 billion (+37 percent).

4. Equipment and Services. The considerable advances in medical technology in recent years has led to great investments in new and costly medical services and equipment. Unlike advances in other industries, new technology in medicine has not, in general, been cost-saving. Not only is the new equipment and its installation expensive, but the operating costs, including the cost of trained personnel, are also very high. Some examples of recent sophisticated and expensive treatment techniques include cancer radiation, renal dialysis, organ transplants, open heart surgery, and body scanners, including the controversial CAT (brain) scanner. In addition to the high costs of medical equipment is the problem of the frequent duplication of sophisticated technology. Each hospital in a community believes it must have all of the most recent techniques and equipment, no matter how expensive nor how small the demand for such services. There is little incentive for hospitals in a community to cooperate in acquiring and offering these services.

The necessity for services provided by a hospital or a physician are also an issue in rising health costs. Superfluous or duplicated laboratory tests, unnecessary surgery, and excessive hospital stays all contribute to higher costs. In many cases, excessive tests are performed to protect the physician against the threat of malpractice charges. In addition to the costs of this so-called "defensive medicine," the direct costs of malpractice insurance for both physicians and hospitals has dramatically increased in recent years. Testimony at public hearing held by the Council on Wage and Price Stability in 1976 indicated that the average malpractice insurance cost per New York hospital bed in 1975 increased from \$348 to \$1,447. In Texas, the malpractice costs for hospitals in 1970 were approximately \$13 per bed per year; by 1976, they had risen to \$2,300 per bed for some hospitals.

C. Third-Party Coverage

In health-financing terminology, the phrase "third party" refers to an organization that pays for health services. (The patient

and the provider of the services are the other two parties.) The third-party payor may be a public organization such as Medicare or Medicaid, a nonprofit organization such as Blue Cross or Blue Shield, or a private or commercial insurance company.

Before the advent of the Medicare and Medicaid programs in the mid-sixties, direct payments by individuals (including "out-of-pocket" payments such as deductibles and coinsurance amounts and other costs not covered by insurance) represented the largest source of funds for personal health care, with private third-party funds making up a larger portion than public third-party payments. By 1970, after Medicare and Medicaid were in operation, direct payments paid only 40 percent of expenditures, with public third-party coverage (34 percent) exceeding private coverage (26 percent).

By FY 1976, third-party payments constituted 68 percent of personal health care expenditures, more than twice the percentage in FY 1950 when third-party payments were only 32 percent of personal health care expenditures. The following table presents the data:

AMOUNT AND PERCENTAGE DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES,
BY SOURCE OF FUNDS, SELECTED FISCAL YEARS, 1929-1975

	<u>Total</u>	<u>Direct Payments</u>	<u>Third-Party Coverage</u>		
			<u>Total</u>	<u>Private</u> ^{1/}	<u>Public</u> ^{2/}
<u>Fiscal Years</u>	<u>Aggregate Amount</u> (in millions of dollars)				
1929	\$ 3,165	\$ 2,800 ^{3/}	\$ 365	\$ 83 ^{3/}	\$ 282
1940	3,414	2,799 ^{3/}	615	92 ^{3/}	523
1950	10,400	7,107	3,293	1,191	2,102
1960	22,729	12,576	10,153	5,223	4,930
1965	33,498	17,577	15,921	8,963	6,958
1970	60,113	24,272	35,841	15,296	20,545
1975	105,745	35,553	70,191	28,225	41,966
1976 ^{4/}	120,431	39,099	81,332	32,915	48,417
<u>Percentage Distribution</u>					
1929	100.0	88.5 ^{3/}	11.5	2.6 ^{3/}	8.9
1940	100.0	82.0 ^{3/}	18.0	2.7 ^{3/}	15.3
1950	100.0	68.3	31.7	11.5	20.2
1960	100.0	55.3	44.7	23.0	21.7
1965	100.0	52.5	47.5	26.7	20.8
1970	100.0	40.4	59.7	25.5	34.2
1975	100.0	33.6	66.4	26.7	39.7
1976 ^{4/}	100.0	32.5	67.5	27.3	40.2

^{1/} Includes insurance benefits.

^{2/} Includes Federal, State, and local expenditures.

^{3/} Direct payments include any insurance benefits.

^{4/} Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

Of the various types of personal health care, hospital care has the largest portion of expenditures paid for by third-party coverage. This amount has risen from 66 percent in FY 1950 to 91 percent in FY 1976. The consumer of hospital care in 1976 is, on the average, directly responsible for only 9 percent of the costs of hospital care. The following table presents the data.

AMOUNT AND PERCENTAGE DISTRIBUTION OF HOSPITAL CARE EXPENDITURES, BY
SOURCE OF FUNDS, SELECTED FISCAL YEARS, 1950-1976

Fiscal Year	Total	Direct Payments	Third-Party Coverage		
			Total	Private	Public
			Aggregate Amount (in millions of dollars)		
1950	\$ 3,698	\$1,265	\$ 2,433	\$ 743	\$ 1,690
1955	5,689	1,344	4,345	1,731	2,614
1960	8,499	1,583	6,856	3,348	3,508
1965	13,152	2,434	10,718	5,788	4,930
1970	25,879	3,174	22,705	9,553	13,152
1975	48,224	4,741	43,484	16,950	26,534
1976 <u>1/</u>	55,400	4,909	50,491	20,095	30,396
			Percentage Distribution		
1950	100.0	34.2	65.8	20.1	45.7
1955	100.0	23.6	76.3	30.4	45.9
1960	100.0	18.6	81.4	39.4	42.0
1965	100.0	18.5	81.5	44.0	37.5
1970	100.0	12.3	87.7	36.9	50.8
1975	100.0	9.8	90.1	35.1	55.0
1976 <u>1/</u>	100.0	8.9	91.2	36.3	54.9

1/ Preliminary estimates.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

The increasingly large contribution of third-party payments to expenditures for health services has had a considerable impact on the demand for and the cost of health services. The demand for expensive health care is likely to be higher when both the patient and the doctor know that the third-party payor, not the patient, will be paying most of the bill. This is especially true with hospital costs, where the patient pays less than 10 percent of the costs directly. This process of third-party coverage increasing the demand for additional and more costly services, and thus driving up the costs of health care, may even have a spiraling effect because as the costs of health care increase, the pressure for more comprehensive third-party coverage increases, enabling even more costly care to be provided. An additional cost resulting from the growth of third-party coverage is the expense incurred in administering these payment plans and the expense to providers of filing the numerous claims forms necessary to receive payment.

A recent example of how costs can be driven up by increased third-party coverage is Medicare's chronic renal disease program authorized by the Social Security Amendments of 1972. In FY 1974, the cost to the Medicare program for patients with chronic renal disease was \$250 million. Three years later, the cost of the program has doubled to more than half a billion dollars in FY 1977. Estimates of future costs are \$1.5 billion by 1981.

D. Reimbursement Methods

The methods by which providers of health care--specifically hospitals and physicians--are reimbursed for their services have a significant impact on the cost of such services. This is because the reimbursement methods for these health care providers contain few incentives which encourage cost control or efficiency.

1. Hospital Reimbursement. Hospitals are reimbursed according to either the costs they incur in delivering patient care or the prices or charges they assign for different units of service they supply to patients. The predominant method of reimbursement, used by Medicare, Medicaid, and most Blue Cross plans, is cost-based reimbursement. Cost reimbursement involves determinations, in accordance with established principles, of the actual costs incurred by the hospital in providing patient care. Payments are made at periodic intervals based on estimated operating costs with retroactive adjustments made for each accounting period.

This retrospective cost-based reimbursement mechanism has come under increasing criticism in recent years and has been cited as one of the contributors to the inflation in health care costs. Specifically, this method of paying for hospital care is viewed as inflationary because: (a) it fails to set effective limits on the costs to be reimbursed; and (b) because it fails to offer incentives for efficient performance or, alternatively, to create disincentives for inefficient operation. In effect, retrospective cost reimbursement virtually guarantees payment for costs, thus relieving the hospital from pressures to contain costs. Moreover, cost-based reimbursement may actually provide disincentives for efficiency since the less a hospital spends, the less reimbursement it will receive from the third-party payor.

Charge-based reimbursement similarly provides few incentives for cost control. Reimbursement by third-party payors (some Blue Cross plans and most commercial insurers) takes many forms. Plans may reimburse on the basis of "billed charges," without making any special effort to determine that they are reasonable. In other cases, reimbursement is based on charges which the hospital must demonstrate, through budget review by the third party, are cost-related. Another approach bases payment on "negotiated charges," in which the third-party payor may examine not only the hospital's budget but its management efficiency and effectiveness in arriving at a negotiated charge rate.

Under all of these methods of charge-based reimbursement, there is great freedom and latitude granted the hospitals. Pricing policies within a hospital are based on target revenue levels, and frequently the charges for certain services may be entirely unrelated to the costs associated with the production of those services. Cost increases are easily countered by changes in the hospital's charge structure. There is little pressure on the hospital to economize or to resist cost increases in its operation.

The increase in national health expenditures for hospital care is shown in the following table. Not only have aggregate expenditures increased, especially since the mid-sixties when Medicare and Medicaid began, but also hospital care as a percentage of total health expenditures has increased.

NATIONAL HEALTH EXPENDITURES FOR HOSPITAL CARE, AMOUNTS AND PERCENT OF TOTAL, SELECTED FISCAL YEARS, 1929-1976

<u>Fiscal Year</u>	<u>Aggregate Amounts (in millions)</u>	<u>Per Capita Amount</u>	<u>Percentage of Total National Health Expenditures</u>
1929	\$ 651	\$ 5.29	18.1
1940	969	7.23	25.1
1950	3,698	24.09	30.7
1960	8,499	46.56	32.9
1965	13,152	66.87	33.8
1970	25,879	124.74	37.4
1975	48,224	222.66	39.5
1976 ^{1/}	55,400	253.70	39.8

^{1/} Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

2. Physician Reimbursement. There are a number of ways physicians are paid for their services. Although some physicians are paid salaries, e.g. many of those employed by governments, the great majority bill for their services on a fee-for-service basis. Fee-for-service means that the physician bills a charge for each service that he renders. A physician may take a number of considerations into account in setting his fees. These include such factors as the amounts charged by other physicians in the area, the net income he wishes to generate, his qualifications and experience, his expenses, and the time required to perform

a given procedure and its complexity. Critics of fee-for-service argue that it provides the physician with an incentive to provide excessive or even unnecessary services (visits, procedures, tests, etc.) since the more services he provides, the more he will be paid.

Third-party payors usually pay a physician's billed charge in full if the charge: does not exceed the billing physician's usual fee, does not exceed the amount that is customarily billed for the service by other physicians in the area, and if it is otherwise reasonable. Health benefit plans that set allowable fees in this manner are called "UCR" (i.e., usual, customary, and reasonable) plans. Today, the major national Blue Shield accounts and many of the plans offered at the local level have adopted the UCR method of setting allowable fees. Commercial insurance company UCR plans vary depending on company policy. Generally the commercial companies do not screen claims against the billing physician's usual fees. An allowance is usually made in full if the billed fee does not exceed the level prevailing in the area. Medicare also reimburses according to the UCR approach, but the cutoff point for determining "prevailing charge" is somewhat below the 75th percentile. On the average, Medicare allows only about 80 percent of billed charges. Under the Medicaid program, most States pay physicians according to fee levels set lower than those of the Medicare program.

A second major problem area concerns hospital-based physicians who bill for their participation in services which involve a large institutional input. For example, a clinical laboratory test is ordinarily carried out by a hospital technician using hospital equipment on hospital premises. The technician works under the general supervision of a physician (i.e. a pathologist) who, while not directly involved in the individual tests, is responsible for the operation of the laboratory. The physician may work only part-time, depending in part on the size of the hospital and the availability of Ph.D. scientists to share in the supervision of the laboratory. In the case of a small hospital, the physician may work in the laboratory only a few days a month. Since the amount of physician input can vary so greatly from hospital to hospital, it is not possible to judge the reasonableness of his charges for laboratory tests by comparing them to the fees charged by other pathologists. Moreover, even if two pathologists had identical fee schedules and worked the same number of hours, one could receive a much higher income than the other depending on the number of tests performed.

Hospital-based physicians are, in some cases, paid more than other physicians. However, because of these different variables, third parties have not been able to develop easily administered techniques for judging the reasonableness of the bills they receive for the services of hospital-based physicians where the physician serves largely as a supervisor of hospital personnel.

Another method of payment--capitation--has attracted public attention in recent years because of the increased interest in prepayment group practice and HMO's. Under this method, physician groups are paid on a flat rate by the insuring organization for the care of each patient

for whom they assume responsibility. The physicians providing the services are then paid by the HMO by salary or on a modified fee-for-service basis, depending on the type of HMO. In most HMO's, incentives are built into the capitation to encourage cost control. For example, if costs are less than anticipated, the savings may be returned to the physician group to be distributed among its members or, if an individual physician has contracted with the HMO to provide care, he may receive a percentage of the savings. Thus there is positive incentive to control costs, since the savings may be distributed back to the physicians.

The following table shows national health expenditures for physicians' services. Although physicians' services as a percentage of total national expenditures has declined, the expenditures for such services have increased rapidly since Medicare and Medicaid began in the mid-sixties.

NATIONAL HEALTH EXPENDITURES FOR PHYSICIANS' SERVICES--AMOUNTS
AND PERCENT OF TOTAL, SELECTED FISCAL YEARS, 1929-1976

<u>Fiscal Year</u>	<u>Aggregate Amounts (in millions)</u>	<u>Per Capita Amount</u>	<u>Percentage of Total National Health Expenditures</u>
1929	\$ 994	\$ 8.08	27.7
1940	946	7.06	24.5
1950	2,689	17.52	22.4
1960	5,580	30.57	21.6
1965	8,405	42.74	21.6
1970	13,443	64.80	19.4
1975	22,925	105.85	18.8
1976 <u>1/</u>	26,350	120.67	18.9

1/ Preliminary estimate.

Source: Gibson, Robert M., and Mueller, Marjorie Smith. "National Health Expenditures, Fiscal Year 1976." Social Security Bulletin, Vol. 40, No. 4, April, 1977.

E. Pluralism in the Health Care Industry

The great variety in the types of health care facilities, programs and payment mechanisms in this country makes it difficult to develop a single coherent health care policy or to agree on any single plan of action to control rising health care costs. There are a multitude of providers such as hospitals, physicians practicing various specialties,

other kinds of practitioners, nursing homes, extended care facilities and other nursing care institutions, and community health centers. These are operated by private nonprofit organizations, the Federal Government (Veterans' Administration, Department of Defense), State and local governments, and by private enterprise. Many of the bills are paid by the individual patient out of his own pocket. Programs which pay for the costs of medical care vary from the Federal Government's Medicare and Medicaid programs, to Blue Cross and Blue Shield programs, to private health insurance. Some believe that the degree of fragmentation in the health care area poses a substantial barrier to any unified, concerted effort to contain health costs.

F. Personal Health Habits--Environmental Factors

Some important factors contributing to expenditures for health care services are the personal health habits, environmental factors and other problems which contribute to "bad health." While the incidence of such induced diseases may not necessarily have increased over time, the effects of controllable habits and environmental circumstances leading to "bad health" are significant. Unhealthy lifestyles and habits leading to poor health include smoking, the abuse of alcohol and other drugs, improper nutrition, lack of exercise, and failure to have children inoculated. Environmental factors include air and water pollution, work hazards, automobile accidents, and accidents in the home.

IV. PROPOSALS TO LIMIT HEALTH EXPENDITURES

Numerous measures designed to control health care expenditures have been proposed or attempted over the years. There has been much controversy, first, whether such controls were necessary; second, which factor leading to increased expenditures was the most significant and therefore should be controlled; and third, whether the controls would do more harm than good. There are several reasons why controls have been an issue. The intervention of government into the affairs of the health care industry have been viewed by some with suspicion. Regulation of any kind has been thought by others to interfere with the "free market" operation of the medical economy and to compromise the independence and freedom of action of the providers that would be affected. Another debate has centered around the issue of whether cost controls would result in a reduced quality of health care. However, the increase in health care expenditures has significantly strengthened interest in examining measures to curb rising health expenditures.

A. Economic Stabilization Program

The Economic Stabilization Program (ESP) was a series of economy-wide wage and price controls which were designed to reduce inflation by about one-half in the economy as a whole. The program began with a freeze on wages and prices in August, 1971 (Phase I). The freeze was replaced in December, 1971 with control programs for each major sector of the economy (Phase II), including health.

For the health care industry, Phase II consisted of a ceiling for hospitals and other institutions of 6 percent per year (adjusted for changes in volume of services) on increases in prices and revenues per inpatient day. In no case could there be more than a 1.7 percent increase in expenditures for new technology, a 5.5 percent increase for non-wage-related expenses or a 2.5 percent increase for wage-related expenses. Noninstitutional providers, such as physicians and dentists, were allowed a 2.5 percent increase per year in their fees.

Phase III, which lasted from January 11, 1973, to June 13, 1973, was an extension of Phase II for many areas of the economy, including the health care industry. On June 13, 1973, another freeze on the prices of all commodities and services began and lasted until July 1, 1973, when it was superseded by Phase IV. Phase IV covered many industries including health until April 30, 1974, when ESP authority expired, and the program ended.

The stated goals of the hospital controls under Phase IV were to reduce the excessive rate of increase in the cost of hospital stays; to moderate increases in new services and to selectively control capital expenditures; to provide economic incentives for the substitution of less expensive ambulatory care for inpatient hospital care; to provide for the development of State, rather than Federal, administration

of health care controls; to allow internal flexibility and incentives for health care managers to improve productivity; and to be responsive to cost-saving innovations, such as health maintenance organizations.

For the health care industry, Phase IV established a limitation of 7.5 percent on increases in hospital charges and costs per inpatient admission, with adjustments for volume of services, and made provision for reimbursing the institution for new operating costs resulting from new and approved capital expansions. Also, a 6 percent increase limit was set for outpatient charges per procedure.

A 4 percent increase limit was placed on medical practitioners' aggregate annual fees, with a 10 percent increase limit for individual fees over \$10 and a \$1 increase limit for fees under \$10. Also, a 6.5 percent increase limit was set for long-term care institutions' average realized revenues per day. This limit was applied separately for the various classes purchasers (e.g. Medicare, Medicaid, all other).

The Phase IV controls differed from Phases II and III in their emphasis on the total cost of a hospital stay rather than the individual price per day. In addition, Phase IV treated separately increased operating costs due to capital expenditures and placed controls on hospital outpatient services.

Before ESP went into effect, the annualized rates of increase in prices of medical care and of hospital charges (semi-private room) exceeded that of prices in the economy as a whole. During the various phases of ESP (August 1971 to April 1974), not only were the rates of increase for medical care and hospital charges reduced, but the rates of increase dropped below prices in the economy as a whole. In the post-ESP period, after the controls were lifted, the rates of increase for medical care and hospital charges rose above the pre-ESP levels and once again exceeded prices in the economy as a whole (see table on Page 8). This temporary effect in lowering prices is due in part to the fact that ESP was a cost containment program which did not attempt to address the underlying problems in the process of health care delivery, some of which are the unusual system of supply and demand where the users of health care usually pay only a small portion of the costs they incur; the maldistribution of manpower; and the high costs of medical and technological advances.

B. Efforts to Limit Reimbursement to Providers

1. Hospitals. Dissatisfaction with rising hospital costs has lead to considerable discussion of and experimentation with new approaches to paying for hospital care. Alternatives to present retrospective cost-based reimbursement systems include many approaches which are frequently described as "prospective reimbursement." The Social Security Administration defines these approaches as "the financial remuneration of health care providers whereby the amount or rate to be

paid is established prior to the period over which the rate is to be applied." The amount or rate to be paid may be determined through a number of methods such as prospective budget review and approval, rate review or rate setting, or the use of formulas to determine rates of payment or to limit payments under current reimbursement practices.

The proponents of prospective reimbursement argue that if a hospital could know its payment rate before it renders its services, it would have more motivation to see that these services were produced in the most efficient manner, since its solvency would depend on keeping its spending within the limits of its anticipated revenues. The hospital would have positive incentives for efficiency as well because, if it could produce its services more cheaply than the predetermined rate allowed, it could pocket all or some of the difference.

The major examples of efforts to limit hospital costs follow below:

a. Hospital reimbursement limits under Medicare and Medicaid. The 1972 amendments to the Social Security Act authorized the Secretary of Health, Education, and Welfare to establish limits on the costs to be reimbursed under the Medicare program. The Secretary was given broad discretion in the selection of the institutions and kinds of costs to which the limits are applied and in the method of setting the limits.

Under present policy, cost limits are established each year for the routine cost portion of hospital costs--essentially, the cost related to bed and board. Individual hospitals are assigned to groups, depending on the hospital's size and the per capita income of the area where it is located. The cost limit for the hospitals in each group is set by a formula that establishes the limit high enough to permit the routine costs of well over 80 percent of the hospitals to be covered in full.

In FY 1975, the first full year of implementation, approximately 345 hospitals were reported to be in excess of the limit by a total of \$36 million. Fiscal year 1976 data are not yet complete, but thus far 334 hospitals have been reported to be in excess of the limit; it is expected the total will increase above the FY 1975 number when all reports are in.

The objective of the cost-limits provision is to establish ceilings that reasonably prudent and cost-conscious hospitals can be expected to live within. By setting the limits in advance, it was intended that high-cost hospitals could, if they wished, undertake cost reduction measures to avoid loss of reimbursement. Where a hospital exceeds the limit and wishes to make up the lost income by imposing a special charge on patients, the patients must be advised of the situation in advance.

b. Federal experimentation and State programs. The Social Security Amendments of 1967 and 1972, and Section 1526 of the National Health Planning and Resources Development Act of 1974, authorize broad programs of experimentation in prospective reimbursement and other alternative reimbursement and rate setting methods. Under its authority, the Social Security Administration evaluated State and local systems which were already operating with Federal funding, and began supporting demonstrations, evaluations, and developmental projects in other States.

Three principal prospective reimbursement methodologies have been identified which are generally used in some combination:

-- Budget review approach, involving setting or approval of reimbursement rates based on a detailed review of the projected budgets of individual hospitals and their departments. This approach is used in Maryland in its rate setting, and is used in New Jersey and Connecticut in combination with a formula approach. Budget review can be done by exception, involving review only of those portions of an institution's budget exceeding established screens.

-- Formula methods, involving the use of formulas to determine rates of payment, or to determine ceilings or target rates under current reimbursement practices. New York uses a formula approach, and other States use this approach in combination with the other methods.

-- Negotiated rates, involving joint decision-making by the hospital and the rate setter. Rhode Island uses a negotiated budget methodology.

The Social Security Administration has identified five elements which it believes are essential in a prospective rate setting system:

- All hospitals within a given system should submit accounting and reporting data based on uniform systems.
- Health planning and rate setting should be closely coordinated.
- Prospective rate-setting systems should focus on total hospital expenditures including utilization factors.
- Prospective rate-setting systems should cover all payors.
- Hospital participation in prospective rate-setting systems should be mandatory.

In addition to evaluations of ongoing activities, the Social Security Administration is funding a number of demonstration and

developmental activities to gather further information on rate-setting systems.

A recent American Hospital Association survey identified rate-regulation programs operating in 25 States, including several Blue Cross prospective reimbursement plans. Budget review was the principal method used but often in combination with other methods. A total of 2,070 hospitals and 1,407 nursing homes participated in the programs surveyed. In addition to the 25 programs currently in effect, the survey identified 13 States as contemplating some form of program.

c. Legislative proposals in the 95th Congress. Two bills were introduced in the 95th Congress which contain provisions to control hospital costs. One was the Carter Administration's proposal (H.R. 6575/S. 1391), a temporary hospital cost-containment program which establishes a limit on increases in hospital revenues from each class of payor for inpatient services, pending the development of a permanent program. The other, initially introduced by Senator Talmadge (S. 1470/H.R. 7079), proposes a new method of reimbursement for hospital routine operating costs under the Medicare and Medicaid programs by providing incentives to hospitals to keep their costs below the average costs of similar hospitals and by establishing reimbursement ceilings.

2. Physicians. As noted above, the office-based physician takes a number of considerations into account in setting his fees. Factors such as the prevailing fee level in the community or the ability of patients to pay for a given service have served to determine the rate of growth of these fees. With public and private third-party payors assuming greater responsibility for payment of the physician's fee, these implicit constraints have been formalized in fee schedules and reimbursement policies.

Traditionally, the insurer has listed the maximum amounts payable for individual services in a published fee schedule. However, health insurance plans with fixed fee schedules offer no assurance to purchasers that the allowable fees will adequately cover their medical expenses. Some fee schedules, in fact, have fallen far behind prevailing fee levels.

In response to the demand for better protection, insurance organizations developed health benefit plans in the 1960's that set upper limits on the physician fees they would reimburse, but limits that were believed high enough so that a physician's billed charge would be paid in full so long as it met the "usual, customary, and reasonable" (UCR) criteria mentioned above.

The UCR plans developed by Blue Shield have usually set the upper limit on the fees they normally allow at the 90th percentile; so that either 90 percent of the fees being billed in the area are allowed in full or 90 percent of the physicians in the area will have their charges allowed in full. Other plans set their allowable charge limits high enough to satisfy both of the foregoing requirements.

Today, the major national Blue Shield accounts and many of the plans offered at the local level have adopted the UCR method of setting allowable fees. Unlike the older plans with income limits, the Blue Shield UCR plans require participating physicians to accept Blue Shield allowable fees as full payment regardless of the patient's income level.

a. Medicare Payment Policies. The physician reimbursement provisions of the Medicare program were modeled after existing UCR plans. A succession of administrative policies and legislative changes have been adopted since the original 1965 legislation to limit increases in the amounts allowed as reasonable charges for Medicare reimbursement. Two of these policies mandated by the Social Security Amendments of 1972 provide that:

-- The customary charge recognized for a particular physician for a given service is to be updated each year and is to be based on the actual charges made by that physician during the preceding calendar year. This creates as much as an 18-month delay in recognizing increases in the physician's customary charge.

-- The prevailing charge limit for a particular service in an area is updated each year and is set at the 75th percentile of customary charges made by physicians in that area for similar services during the preceding calendar year.

The increasing restrictiveness of the Medicare allowable fee policies was seen as necessary in view of the large increases in physicians' fees that have taken place since the program began. First, by limiting allowable fees, Medicare program costs are reduced. Limits on Medicare allowable charges also serve to dampen fee increases by holding the physician to the allowable charges and by strengthening beneficiary pressures on physicians to keep their fees within covered limits.

b. Medicaid Payment Policies. The original Medicaid legislation enacted in 1965 did not place any limit on the physician fees which the States could reimburse. The States, however, did set limits of their own, typically less than usual, customary, and prevailing charges.

The Social Security Amendments of 1967 required that State Medicaid plans must assure that "payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." In 1971, Federal regulations were issued providing that payments to physicians and other practitioners could not exceed the "prevailing charge" recognized under Medicare. This regulation was embodied in law by the Social Security Amendments of 1972.

Some State Medicaid programs pay physicians the same amounts as are allowed under Medicare. Most, however, base their payments on fee levels that prevailed during an earlier period than the

Medicare base period or set the limit on physicians' payments in relation to a lower percentile than Medicare. In some cases, the State makes further reductions in the amounts payable in order to bring program costs within budgetary restraints set by the State.

c. Physician Reimbursement Studies. Research data on the economic aspects of physician practice are very limited at this time. To correct this deficiency a number of studies have been undertaken to study the effects of alternative reimbursement methods. This research will utilize data collected by insurance carriers, medical organizations, consumer groups, consultants, and others to investigate and clarify the issues associated with payment for physicians' services.

C. Health Facility Planning

A number of efforts to plan for increases in health facilities, services, and equipment have been undertaken, with one goal being to limit unnecessary, costly surpluses in health resources. Descriptions of these efforts follow.

1. Hill-Burton Program. The earliest Federal effort on behalf of health planning was incorporated as part of the Hill-Burton program enacted in 1946. Primarily designed to provide funds for construction and modernization of health facilities, the program also stipulated that each State conduct a survey of its need for various health facilities and develop an individual State plan to meet these needs. However, various evaluations of the program (now largely replaced by the National Health Planning and Resources Development Act of 1974) have revealed that it was hardly a victory for health planning. Geographic location of hospitals built under Hill-Burton often bore no detectable relationship to those areas where health levels were worst. Critics charged that the program may have actually contributed to the current problem of excess bed capacity, particularly in rural areas where population has dwindled since facilities were constructed. Perhaps most importantly for health planners, the Hill-Burton formula for projecting need for facilities was based on current hospital utilization rates, thus not accounting for trends and prospective changes toward more efficient and appropriate utilization of hospital beds.

2. RMP's and CHP's. During the 1960's, the government embarked upon a series of programs to support and integrate health planning activities at the regional, State, and local levels, including the regional, or areawide, voluntary health facilities planning agencies (1964), the Regional Medical Programs (1965), and the Comprehensive Health Planning Program (1966). Despite their many contributions, these programs were hampered by austere financing, overlap and duplication of responsibilities, and absence of a sufficient mandate for implementation of their plans. Health planners were concerned over lack of Federal guidance as to national health priorities and goals. Planning agencies were in turn accused of paying insufficient attention to cost containment as it related to capital development and expansion.

3. P.L. 93-641. Concerned over the fragmentation and mixed success of earlier planning efforts, Congress moved in 1974 to combine and integrate these programs through enactment of the National Health Planning and Resources Development Act (P.L. 93-641). The Act provides for the creation of a nationwide network of about 200 local Health Systems Agencies (HSA's) and the designation in each State of a State Health Planning and Development Agency assisted by a Statewide Health Coordinating Council. Among the responsibilities of the new HSA's are the development and implementation of plans for needed health services and facilities in their respective health service areas, allocation of grants for development of needed resources, and approval of each proposed use of Federal health funds in their area. State agencies are to prepare State health plans and administer certificate-of-need programs whereby proposed construction of health facilities must be approved as satisfying a community need.

The primary missions of the new planning agencies include (1) coordination among the diverse elements in the health care delivery system; (2) development of necessary health resources while preventing costly surpluses; (3) improvements in the distribution, efficiency, continuity, and quality of health care services; and (4) restraint over cost increases for health services. The last goal--cost containment--is viewed by many as perhaps the most crucial and most difficult to attain. For example, a report by the Institute of Medicine states:

"This will require the making of difficult and potentially unpopular cost-benefit judgements. Such judgements, if they are to be constructive, will have to confront the realities of limited resources--to weigh the cost part of the equation in the balance with such benefits as quality and access. This involves the making of choices which, in many cases, will hurt some important interests in the community."

Although armed with broader mandates and stronger sanctions than in the past, health planners may still face serious obstacles in a system where the public good is only vaguely defined and where the interests of private owners, business, and professional organizations have frequently predominated over the need for economy and public accountability.

Significantly, the revised planning law provides that States must enact and administer certificate-of-need (CON) programs, to be applied to all proposed new institutional health services, in order to remain eligible for Federal funding under the Planning Act, the Community Mental Health Centers Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act. State CON programs must contain appropriate sanctions, e.g. denial or revocation of licensure, or civil or criminal penalties, which will preclude development of any such services for which CON approval has not been received.

Although more than half the States already have CON laws in effect, few have been in operation for three years or more. Furthermore,

various studies on existing CON programs have questioned their overall effectiveness in reducing the total dollar volume of investment in capital plant of health facilities. Reports have indicated that CON has appeared to influence the composition of investment by retarding expansion in bed supplies, but concurrently increasing investment in new services and equipment. Hospitals have often anticipated CON legislation by increasing investment in the period immediately preceding enactment.

CON programs now in effect have few, if any, controls to force institutions that are already in existence to reduce, close, or convert unneeded beds or services. Some States, however, have instituted the practice of denying CON approval for any new service or replacement of equipment sought by an existing facility unless it voluntarily reduces idle bed capacity, retires an underutilized service such as obstetrics, or takes other action viewed by the planning agency as desirable for reasons of economy or efficiency. As a result, CON programs have been criticized on grounds that they (1) allow for continued operation of many old or inefficient facilities, but limit entry into the market of new providers, and (2) exert unfair leverage on established institutions wishing to upgrade services or modernize existing plant, but apply no sanctions to nonapplicant hospitals operating uneconomic or ineffective services. Many planners fear that the absence of "decertification" or "recertification" authority over existing facilities will handicap any attempt to redistribute health resources on a more equitable and cost-effective basis.

4. Section 1122 of the Social Security Act. Prior to the enactment of P.L. 93-641, the Federal Government had given its formal approval of the CON concept in the 1972 Social Security Amendments. The amendments adopted a new Section 1122 of the Social Security Act providing certain limitations on Federal participation in capital expenditures under the Medicare, Medicaid, and Maternal and Child Health programs. The Secretary of HEW was authorized to withhold reimbursement for depreciation, interest on borrowed funds and a return on equity capital in connection with capital expenditures that had been made in spite of a finding that they were inconsistent with State or local health facility planning requirements. The provision applied only where the expenditure (1) exceeded \$100,000, (2) changed the bed capacity of the facility, or (3) substantially changed the services provided by the facility.

At the present time, 40 States have chosen to participate in the Section 1122 program. Generally speaking, those States which already had CON programs have proved to be the ones most willing to participate. The program has also been attractive to States facing serious cost crises. Participation in Section 1122 has offered the States an opportunity to offset some of the costs of their existing CON programs or to place some kind of cap on their spiraling institutional costs. In some instances where State legislatures have been resistant to CON legislative proposals, governors have been able to use the 1122 authority to accomplish similar ends.

By 1975, all States but West Virginia had either a certificate-of-need law or a Section 1122 agreement with HEW, or both. In addition, some commercial lenders and governmental loan programs have recently instituted the practice of requiring an "1122 approval" before agreeing to help finance a particular project.

Several evaluations of the Section 1122 program have disputed its overall effectiveness in controlling total dollar investment in hospital capital plant. One study revealed that 75 percent of the sampled States had approved hospital bed supply in excess of 105 percent of their published Hill-Burton need projections five years hence. Other findings showed that, regardless of the type of controls in place, States approved more than 93 percent of all projects submitted and 90 percent of the dollar expenditures proposed. Proposals to purchase equipment or add new services were almost always approved, whereas new construction or expansion proposals had a comparatively lower approval rate. Those States which were most consistently effective in controlling hospital beds and assets had either a State rate review program or Blue Cross prospective payment system in place for hospitals. By placing institutions at risk with respect to future revenues, rate control programs apparently forced such institutions to more carefully weigh the economic and financial feasibility of capital projects.

D. Utilization Controls

One method of controlling health expenditures is to control the utilization of health services. Some methods to accomplish this follow.

1. Utilization Review, Professional Standards Review Organizations. During the last several decades, numerous studies have shown that there are substantial differences in the use of health services among similar populations based on differences in the way health care services are organized and paid for, differences in the availability of health resources, and differences in purchasing power. Studies have shown, for example, that persons enrolled in health maintenance organizations were hospitalized less often and had considerably less surgery performed than did otherwise similar groups of persons in the same area. Rates of surgery for such procedures as tonsillectomies may vary among areas in the same State. Such findings suggest an overuse of hospitals and surgery, and have stimulated interest in eliminating unnecessary uses of health services and in finding alternatives to institutionalization of patients.

The area of greatest concern is hospitalization, which is the single most expensive form of health care, with roughly 40 percent of our total health expenditures going for hospitals. There is a general consensus that (a) there is sufficient excessive health services utilization to justify action, (b) that the providers of health services have a major role in determining consumer demand for health services, and (c) physicians and hospitals, but particularly the former, should play the major role in reviewing the performance of their peers. The

original Medicare program required participating hospitals and skilled nursing homes to maintain utilization review committees where physicians would review the necessity and quality of care rendered to hospitalized Medicare patients. As a result of the poor performance of hospital utilization review committees, the 1972 amendments to the Social Security Act established Professional Standards Review Organizations (PSRO's) to review the necessity and quality of care for Medicare, Medicaid, and Maternal and Child Health Program patients. PSRO's are to be established nationwide in each of some 200 designated areas and are to be composed of the physicians in the area who wish to participate. The legislation also called for the PSRO's to establish norms or benchmarks for care to be used as a basis for reviewing medical care.

There is considerable controversy regarding the probable effectiveness of PSRO's, which are only now beginning to operate in some areas of the country. While some would argue that establishing norms of care are essential in evaluating care rendered, some critics contend that such benchmarks tend to err on the side of being conservative, i.e. taking all possible steps in rendering medical care, hence their impact may be to increase the number of procedures performed on individual patients. Also, the question of peer review has been questioned by some because of the historical reluctance of medical professionals to criticize and penalize their peers. Health professionals may tend to give their peers considerable latitude in determining how best to deal with their patients. While it is conceded by many that such latitude is essential, it is also recognized by many that such an approach is not likely to depress the quantity of health services provided. There is little in the way of evaluation which demonstrates that either utilization review or PSRO's, to date, have been effective in reducing hospital admissions or the cost of health care.

An approach given considerable support recently has been the second consultation by a physician where another physician proposes to perform surgery. The basis for such support are recent studies done in New York where it was found that second consultations reduced the amount of surgery that was performed. Although the findings have been challenged by some members of the medical profession, a number of insurers have included this option in their health insurance policies.

2. Cost sharing. Most of the available evidence shows that increasing the out-of-pocket costs of health care for consumers reduces or alters their use of health services. Conversely, increased insurance coverage increases consumer use of health services. A major cause of the increased use and cost of hospital services, for example, has been attributed by many experts to the increasing share of hospital bills that are paid by health insurance, both public and private. The sponsors of many major national health insurance proposals have included cost sharing by consumers in the proposals not only as a means of reducing the Federal share of the health costs, but as a means of lessening consumer demand. Recently, General Motors tried unsuccessfully to persuade

the United Auto Workers to include cost sharing in the form of deductibles and copayments as a method of containing costs. Consumer cost sharing is controversial, with critics claiming that it hits the poor the hardest, discourages people from seeking care when they need it, and is administratively cumbersome. They also argue that since providers are the major determiners of demand, any controls should be directed at providers rather than consumers. However, as noted above, studies do show that cost sharing may reduce costs.

E. Alternative Ways of Delivering Health Care

Many of the changes in the delivery of health care services which are intended to save money attempt to do so by substituting less expensive forms of treatment for more expensive ones and by changing patient and provider behavior. For example, there are attempts to provide treatment for particular medical problems on an outpatient or ambulatory care basis rather than providing them in a hospital or other institution. Efforts are being made to delegate tasks previously performed by physicians, dentists, and other health professionals to "extenders" who earn lower incomes than such health professionals. Through steps such as mergers, cooperative activities and consolidation of activities, providers attempt to avoid duplicative work and achieve greater economies of scale. In some instances, changes attempt to shift the burden of providing health care and maintaining health to a greater extent to the patient.

It should be noted that many measures which promise to contain costs may not achieve this result and, in certain instances, can have the opposite effect. If the lower cost service, such as a physician extender, is used to replace a higher cost service, then a savings would take place. However, if the lower cost service is provided in addition to the higher, aggregate spending would be increased. In addition, where cost saving approaches are introduced, there is no assurance that the savings that result will be transferred to consumers, but may be retained by the health industry. The following examples of cost-saving measures, therefore, should be considered only as those which have the potential for lowering overall health care costs and of lowering costs to individual consumers.

1. Health Maintenance Organization. There is considerable evidence that care provided through HMO's can be less expensive than that provided through fee-for-service insurance plans. Unlike fee-for-service medicine, HMO physicians' compensation is fixed and does not vary according to the volume of services they perform. Dr. Theodore Cooper, Assistant Secretary of HEW for Health, noted in November 1975: "Over all, HMO's appear to achieve cost savings of 10 to 30 percent, compared with traditional health care."

A California study (Roemer et al.) produced data on prepaid group practice HMO's, as compared with conventional patterns of medical

care. (Such costs comparisons commonly combine out-of-pocket expenditures with premiums to obtain the total cost of medical care.) The following table shows one of the findings of the study:

COST COMPARISONS

<u>Plan</u>	<u>Average Premium</u>	<u>Out-of-Pocket Expenditures</u>	<u>Total Costs</u>
Commercial Insurers	\$208	\$156	\$364
Blue Cross/Blue Shield	257	190	447
Group Practice Prepayment	271	52	323

The National Advisory Commission on Health Manpower examined health care costs in California in 1965, comparing per capita costs for Kaiser Health Plan members with the per capita costs for all other persons in California. The Commission found:

Depending upon the figure used on non-Kaiser expenditures on physician services, total Kaiser expenditures are either 55 to 65 percent of the average in the State. Even if allowances for noncomparability raise the Kaiser figure by as much as 25 percent, it would still be only 70-80 percent as large as the State figure.

The Social Security Administration, in a study published by Corbin and Krute, compared per capita Medicare reimbursements made to fee-for-service providers and health maintenance organizations. Seven prepaid group practices were examined. Five of the seven had lower per capita costs than those experienced under the fee-for-service reimbursement system.

An important consideration in measuring costs of health maintenance organizations is the type of insurance with which it is compared. Studies show, for example, that increasing health insurance coverage increases the use of health services. The cost of health services provided by health maintenance organizations is most frequently compared with the cost of care provided under other relatively comprehensive health insurance plans, for example, those plans covering Federal employees and other groups with relatively broad health coverage. There may be a need for additional studies which compare the costs of care provided where persons are enrolled in health maintenance organizations with the costs of care provided to persons with less comprehensive insurance as well.

2. Home Care and Extended Care Facilities. Home care and extended care facilities allegedly reduce costs because certain types of illness that currently result in hospitalization may be treated equally

well at home or in an extended care facility. However, it is not known how prevalent these types of illness may be. While the need for home care and nursing home care is substantial, especially among the elderly, relatively few of those who could benefit require hospitalization. Many experts contend that patients for whom hospitalization is justified on medical grounds will not, as a practical matter, be placed in another appropriate setting unless the hospital is operating at near capacity, requiring a serious search for alternatives, or unless incentives are changed, notably for physicians, to cause them to look for alternatives. Moreover, home health care programs that pay for housekeeping and other non-health services may be called on to make substantial expenditures for services now provided at no cost by friends, relatives and volunteers. There is little documentation showing the impact of home and extended care on the overall costs of health care.

3. Physician Extenders. For some time it has been acknowledged that physicians can delegate a substantial number of tasks that they have traditionally performed to well trained assistants, commonly referred to as physician extenders. With adequate support from physicians, physician extenders can diagnose and treat large numbers, estimated as high as 70 to 80 percent, of health problems which physicians have traditionally dealt with themselves. A study of physician extenders, commissioned by the Health Resources Administration of the U.S. Department of Health, Education and Welfare, concluded that "given the assumed task delegations and the expected level of acceptance, the median estimate of the need of physicians in the target years (1980, 1985, and 1990) could be lowered by as much as 22 percent." In a study reported in the "New England Journal of Medicine" in January of 1974, the addition of two physician extenders enabled two family practitioners to increase the number of families under their care by 22 percent in the course of a year.

There are few studies which have dealt extensively with the cost issue, although there are frequent claims that care provided by physician extenders is more economical. Obviously, their impact on health costs will depend on the effect they have on the overall supply of services and on the charges for their services. Similarly, questions remain concerning the training that should be required of physician extenders and the degree of physician supervision needed to protect the interests of the patient.

4. Surgical Centers and Ambulatory Surgery. Surgical centers are free-standing, ambulatory centers designed to perform minor, same-day surgery. Many are privately owned, frequently by physicians. Their principal benefits appear to be patient and physician convenience because of faster scheduling and cost savings. In one area studied, Phoenix, Arizona, it was found that the surgical center was charging less for similar operations and apparently had caused a reduction in prices charged for outpatient surgery by community hospitals in some instances.

However, comparisons based on charges are misleading because to a large extent the hospitals are paid by third parties on the basis

of their costs, which may be quite different from their charges. For example, both a hospital and a surgical center may charge \$100 for a specific surgical procedure. For the surgical center, the \$100 charge is the amount that patients or their third parties are expected to pay. The hospital, on the other hand, is largely reimbursed on the basis of its costs, so that if the cost of performing the procedure in the hospital is more than the \$100 surgical center charge, the hospital would be the more expensive of the two. Alternatively, if the hospital's costs were less than the \$100 charge, the hospital would be the less expensive. Another complicating factor is that some of the overhead costs of a hospital that are paid in connection with a surgical stay will have to be paid by the cost-paying third parties, whether surgical patients go to that hospital or to a surgi-center. Studies to assess the impact of surgi-centers on health costs and the quality of care they afford are currently being carried out by the Department of HEW. In addition to surgical centers, ambulatory surgery can also be performed in outpatient departments or scheduled for the operating rooms of hospitals. Health maintenance organizations such as the Kaiser Health Plans frequently use both approaches as alternatives to hospitalizing patients.

5. Institutional Efforts to Improve Efficiency. In a number of instances, hospitals and other institutions have joined together to share services which have resulted in cost savings or cost containment. The most common arrangement, according to the American Hospital Association, is group purchasing, where a number of hospitals jointly purchase their supplies and some of their equipment. Other shared services include shared laundry services, food, and computer services, which have reduced unit costs. There are instances of hospitals forming consortia for the purpose of lowering clinical costs through such means as agreeing to close pediatric and maternity departments of member hospitals to eliminate an overall surplus of such services, and agreements to refrain from the establishment of duplicative, expensive equipment and services. There is no documentation of the impact these approaches have on the overall costs of care provided through the institutions involved.

F. Health Education and Self Care

Our behavior does affect our health. Recent studies by Lester Breslow and others in California showed that people live considerably longer and have considerably fewer health problems if they observe simple health habits such as getting the right amount of sleep, eating properly, and refraining from smoking and excessive drinking. However, we know relatively little about how to educate and motivate people to assume good health habits in the absence of excessively authoritarian measures.

Another dimension of health education relates to the proper use of health services. Some experts contend that informed health care utilization, e.g. seeing doctors early in the course of medical problems, can lessen the seriousness of such problems and lessen the cost of treatment. As noted in the following section on preventive services, there

is little consensus as to the impact that possible changes in health services usage would have on the incidence of disease or on costs. There is evidence, however, that involving patients with certain kinds of health problems in their own care can improve their prognosis and save money. At the Tufts Medical Center, for example, it was possible to reduce hemophilia patient costs from \$5,780 to \$3,209 per patient by instructing the patients in self-infusion. At the University of Southern California Medical Center, it was possible to reduce emergency room visits by 50 percent for diabetics through a program of counseling and information developed by the Center.

Finally, health education might be able to provide people with a more realistic assessment of the role medical care actually plays in maintaining and improving our health. Advocates of such measures contend that many people believe that larger health care expenditures will automatically bring better health care, and that this unrealistic expectation is the principle justification for increasing demand for more and more expensive health services.

It is frequently noted that much disease and poor health, and the consequent costs, could be prevented or made less severe if we simply applied what we know today about prevention. Prevention, in addition to health education referred to earlier, includes such actions as maintaining clean water and air, sanitation, the fluoridation of water supplies, immunizations against specific diseases, and screening programs. Many of what might be termed traditional public health programs such as the chlorination and fluoridation of water supplies are widely perceived to be effective in reducing disease. Immunizations are also generally effective.

There is widespread disagreement, however, about the effectiveness of such preventive efforts as screening programs and routine physical examinations. The major disagreements regarding screening programs which attempt to detect a wide range of diseases relates to the effectiveness of screening in influencing the incidence of any of the illnesses they attempt to detect. There is more widespread agreement concerning particular types of screening tests for segments for our population, e.g. hypertension screening, pap smears, screening for Rh incompatibility in pregnant women and serologic tests for syphilis in sexually active patients. Such tests meet the criteria of accuracy, physician acceptance of the findings, and the likelihood of patient compliance with prescribed treatment and behavior.

An approach under increasing criticism by health care experts is annual physicals for everyone. Most of the criticism relates to their high cost and the limited use of the findings in maintaining or improving health. There is considerable, although not unanimous, agreement that annual physicals are useful for certain groups such as young children, persons over 40, and persons on their first visit to a new doctor.

In speaking to the issue of prevention, Dr. Richard Spark, an associate clinical professor at Harvard Medical School, stated in a New York Times Magazine article of July 25, 1976:

As unpleasant as it may sound to those who would like to believe otherwise, most diseases can be detected only after symptoms appear. Furthermore, with the exception of hypertension, there is no convincing evidence that treatment of diseases before the onset of symptoms offers any long-term advantage over the treatment that is initiated after the symptoms arise.

G. Industry Efforts to Control Health Expenditures

In commenting on the cost of health care to industry, the Council on Wage and Price Stability reported:

If the trend in contributions to employee health benefit plans from 1965 to 1973 (the latest year for which data have been published) were projected forward to 1975, it would show contributions in 1975 to be over 300 percent of those in 1965.

Health care is a larger cost component of a car built by General Motors than is steel. Business and labor, through payments for the Medicare program, health insurance and out-of-pocket payments for health care, occupational health and safety programs, and health expenditures under the employees compensation programs, may spend approximately as much as the Federal Government for health.

Their large and rapidly rising expenditures for health insurance have prompted business organizations to look for ways of containing health costs. Some companies now advocate health maintenance organizations for their employees as an alternative to fee-for-service medicine. The R. J. Reynolds Tobacco Company in Winston-Salem, North Carolina, recently developed a health maintenance organization for its employees and their families. General Motors attempted unsuccessfully to persuade the auto workers union to increase employee co-payments as a means of reducing the use and cost of health services. Companies such as Goodyear Tire and Rubber Company have contracted with a medical society-sponsored peer review organization in an effort to cut down on the use of unnecessary hospital services. Many companies such as those in the Rochester, New York, area actively support health planning as a means of cost containment.

The Council on Wage and Price Stability analyzed industry efforts to hold down the costs of medical care. They identified the following 93 projects, over half of which were begun during or after 1973.

<u>Projects</u>	<u>Number of Projects</u>
Alternative Delivery Systems (HMO's) . . .	32
Preventive Care	26
Concurrent or Prospective Peer Review . . .	17
Alternative Methods of Provider Reim-	
bursement	16
Coverage of Less Costly Care	15
Claims Review	12
Health Education	8
Miscellaneous	6
Health Planning	5

H. National Health Insurance as an Expenditure Control Device

A national health insurance program without strong expenditure controls could add substantially to the cost of health care. Some who criticize proposals for national health insurance on the grounds that it would be too expensive are concerned not only about meeting existing health care expenditures but also about the possibility that such a program, given the state of the art of applying controls, could not resist the pressures to increase expenditures.

On the other hand, it could be argued that the present fragmented system for financing health services is itself a major handicap to expenditure control that could be remedied by national health insurance. If all or most of the health care providers' incomes were from a single program, a budget could be established that would set an overall limit on the nation's health care expenditures. Also, a single payment program might help restrain increases in health costs by strengthening health facility planning efforts and medical education and training programs designed to provide for a more efficient allocation and use of health resources. It could also be argued that a national health insurance program could offer meaningful financial incentives to encourage changes in the way medical care is provided that would make the health care delivery system more economical.

Given our present knowledge, there is no sure way to determine which of these arguments will prove accurate. The choice will probably hinge more on values and goals--the willingness to pay for specified services--than on technical considerations.

V. QUESTIONS FOR ANALYZING PROPOSALS TO CONTROL HEALTH EXPENDITURES

A number of issues must be addressed in examining proposals to constrain expenditures for health care. The questions below are suggested as a general framework for analysis of expenditure control proposals.

- 1) Would the proposal work--does it provide an effective method of limiting spending?
- 2) Is the limitation temporary or permanent?
- 3) What is the impact of the proposal on providers with various characteristics (i.e., large hospitals, small hospitals, high cost hospitals, low cost hospitals, etc.)?
- 4) What is the impact of the proposal on consumers with various characteristics (i.e., low income, high income, those under governmental programs, those with health insurance, the uninsured, etc.)?
- 5) What is the impact of the proposal on the quality of services provided?
- 6) What is the relationship of the proposal to the general economy? What is the effect of limiting controls to one sector of the economy, such as health care, or even limiting only one sector of health care, such as hospitals?
- 7) How would the proposal be administered?

It is currently impossible to answer many of these questions definitively for the proposals which have been made. Sufficient data are not available, and many are still in the developmental phase or are too recently implemented to begin evaluation. However, the questions can serve as a general framework for analysis and evaluation of proposals to limit the nation's spending on health care.





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